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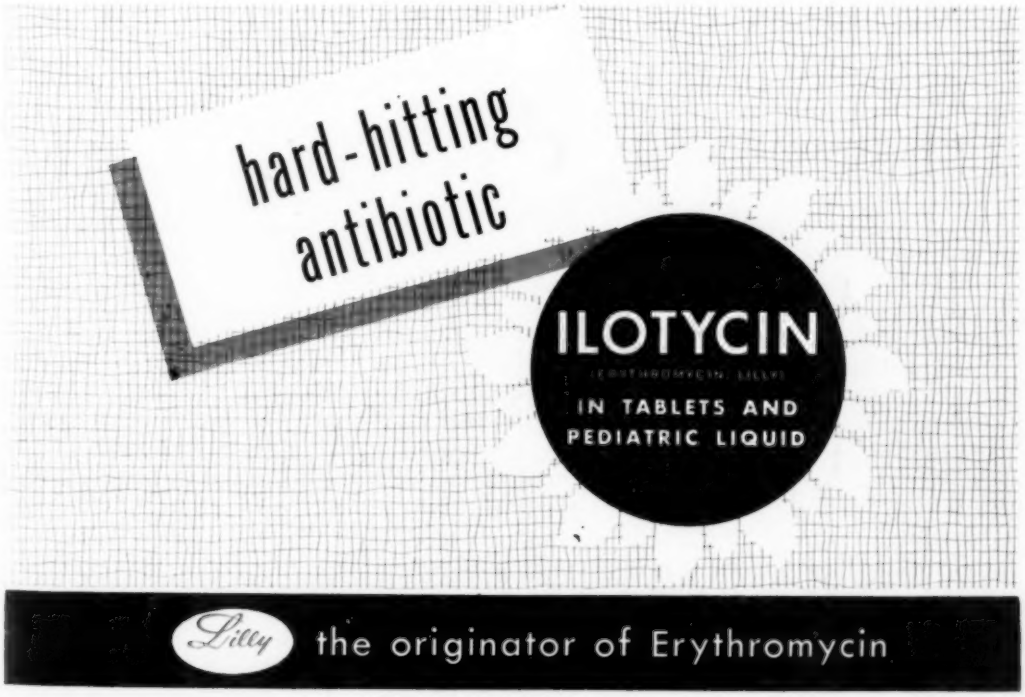

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VOLUME L March, 1954 NUMBER 3

# *Resistant Rickets**

JOHN R. PAUL, JR., M. D.

Charleston, S. C.

Resistant rickets is a metabolic disease which is present from birth, though it is not usually apparent until the second year of life. It is active throughout the formative years and may persist into adult life as osteomalacia. It is practically identical with ordinary rickets from the pathologic, radiographic and bio-chemical standpoints, the chief difference being one of degree.

The disease is not due to any primary fault of the absorption of vitamins, but rather to a specific resistance of the end organs to ordinary or "large" doses of vitamin D, and its requirement of massive doses of the vitamin for the maintenance of proper blood calcium and phosphorus levels, and therefore, the proper laying down and growth of bone.

We neither understand the action of vitamin D as a regulator of calcium and phosphorus metabolism in the normal individual, nor do we understand why the patient with resistant rickets requires more of the vitamin. Certainly there is nothing wrong with the ability of the body to synthesize bone, if a proper menstruum is supplied to the growing tissues.

Experimental work has demonstrated three actions of vitamin D. First, the child with untreated rickets, and also the child with resistant rickets, loses calcium in large quantities in the feces. Practically no calcium is excreted by the kidney, even though the serum calcium be within normal limits. Therefore, vitamin D has a specific action on the gut which promotes absorption of calcium, or prevents excretion through its walls.

Second, Harrison and Harrison have proved that the vitamin specifically increases the renal threshhold for phosphorus, irrespective of calcium levels. This is a tubular reabsorption mechanism.

Third, Smith, Freeman and Dunsky have shown that excessive doses of vitamin D, even in the presence of prolonged experimental calcium starvation, causes hypercalcemia by removing calcium from bone. This action proceeds to renal and tissue calcinosis even in the face of the development of severe osteomalacia, and is irrespective of parathyroid pathology.

Thus, vitamin D controls calcium and phosphorus metabolism. Inadequate amounts cause failure of absorption, or excessive fecal loss of calcium (and also urinary loss of phosphorus), while excessive doses lead to toxic hypercalcemia and calcinosis, even to production of severe rickets and osteomalacia, if calcium is low in the diet.

In the patient with resistant rickets, there seems to be simply a requirement for extremely large doses of vitamin D in order to govern the homeostasis in respect to calcium and phosphorus. There is one difference that has been reported in many cases between resistant rickets and ordinary rickets. Whereas the treatment of ordinary rickets leads to establishment of normal serum phosphorus, the patient with resistant rickets for some reason usually has a persistently low serum phosphorus, even though the alkaline phosphatase is reduced to normal, indicating arrest of the activity of the rachitic process.

In December of 1934, Dr. D. V. McCune[1] reported a case of refractory rickets to a regional meeting of the American Academy of

* Read at the Annual Meeting of the South Carolina Pediatric Society, Sept. 15, 1953.

Pediatrics. He stated that this disease had been well known for several years, and that other cases had been reported by Park, Blackfan and Freudenburg. However, his case is the first that has been reported that responded by healing under the influence of massive doses of viosterol.

Fourteen years later, Dr. McCune[2] reported to the Society for Pediatric Research, that there had been reported in the world's medical literature, only thirty cases of this syndrome. Of these, ten cases came from his own clinic at Babies Hospital in New York.

Since that time there have been a few other reports of series of cases from large institutions. Holt reviewed the literature and presented seven of his own cases in 1951.[3]

The features of the disease are those of florid rickets developing in a child despite adequate diet and supplemental vitamins. The clinical signs usually become evident about the end of the first year, and the true diagnosis is rarely suspected before the age of two. Usually the child will walk at a normal age, and dentition will begin at the usual time. However, some months after the child begins to walk, deformities become obvious and may often cause such pain that the child will stop walking.

Several writers have reported more than one case in a family, either in siblings or in the family tree. Therefore, there is undoubtedly a hereditary factor, though this must be a recessive trait.

The differential diagnosis includes other conditions which cause similar deformities. These are renal rickets or hyperparathyroidism, true idiopathic hyperparathyroidism, the osteochondrodystrophies, chiefly Morquio's disease, the steatorrheas, and the Fanconi syndrome. Holt has pointed out several cases of refractory rickets that were formerly classed as Morquio's disease, even though the diagnosis of rickets was first made on chemical and roengenologic grounds, only to be changed to chondrodystrophy when ordinary doses or even several times ordinary doses of vitamin D failed to effect a cure.

In refractory rickets, the diagnostic findings are: A normal or slightly low serum calcium, a low serum phosphorus, and a markedly increased alkaline phosphatase; in other words, the findings are those of typical active rickets. Kidney function is in all respects normal, glycosuria is absent, though some studies have shown that there may be a transient or relative lowered renal threshhold for sugar. The Sulkowitz test for calcium in the urine is negative. These findings, with typical clinical and x-ray findings and their persistence after a reasonable trial with generous doses of vitamin D make the diagnosis.

It is interesting that every writer who has reported cases of this disease has cited case after case in which orthopedic measures have been instituted, which have either had transient or negative value, or have actually increased the difficulty of the patient. This statement is not intended to reflect in any way on the orthopedic surgeons, because in most cases the orthopedists were only called in after medical men in charge had been unable to make the correct diagnosis or give treatment of value. Most of these cases had osteotomies, which usually healed well even without adequate treatment with massive doses of vitamin D. However, the deformities usually recurred within one or two years, and the end result has usually been one of angular deformities at or near the operative site.

Treatment of the disease must be individualized as the severity of the condition seems to vary considerably. The drug to be used must be a pure vitamin D and not an A & D combination or some other multi-vitamin product. Either vitamin $D_2$ or $D_3$ may be used. Undoubtedly, it is perfectly safe to use tremendous doses from the start, if one is absolutely sure of the diagnosis. Perhaps it is safer to start with some such dose as 50,000 to 100,000 units once a week, for the first two or three weeks, then increase to 500,000 or 1,000,000 units as often as once a day. The dose which causes retention of calcium as judged by x-rays and clinical progress, may be continued until tissue saturation occurs. This point may be determined very simply and safely by daily test of the urine by the Sulkowitz reagent. This reagent can be compounded by any pharmacist.

A positive test is obtained in the normal person after ingestion of 1 or 2 glasses of milk. The small traces of calcium normally present

in the urine after fasting do not precipitate qualitatively. Therefore, this very simple qualitative test is actually made to order, and is a very sensitive test for sub-normal, normal, and abnormal urine calcium, particularly for a growing child.

It is customary to take blood for determination of calcium, phosphorus and alkaline phosphatase fairly frequently during the course of treatment. However, these values will not vary significantly until just before the point of skeletal (and tissue) saturation with calcium is reached. As soon as this occurs, the kidney will begin to spill excess calcium. There will then be a reasonable lag before the serum calcium actually begins to build up to toxic levels.

Thus, when calcium shows up qualitatively in the morning urine, the dose of vitamin D is immediately cut off. The treatment then enters the phase of determining the maintenance dose. Here again, there is marked individual variation. And here again, the daily qualitative test of the urine is an essential guide.

Ordinarily the maintenance dose in the reported cases varies from 50,000 to 100,000 units daily. However, there is also marked variation in vitamin D requirements of particular patients from time to time. Holt stresses the fact that the chief danger to these patients, is immobilization, as for orthopedic surgery. It is probably wise if such procedures are contemplated to omit the vitamin D for one to three weeks before casts are applied. If this is not done, severe hypercalcemia may occur during immobilization with resultant kidney damage that may not be reversible.

## CASE REPORT

S. K., a male infant was born on June 24, 1950, to healthy parents who have one older healthy son.

His birth weight was seven pounds, eight ounces. There were no neonatal difficulties. He had gained only four ounces above his birth weight at three weeks of age when he came for his first office visit. For the next three months, despite a tendency to loose stools, he had an average gain of three pounds a month. Thus, at four months of age he weighed sixteen pounds, five ounces, and at five months he weighed seventeen pounds, four ounces. The family moved to Orangeburg when he was five months old and the child's supervision was continued by a practitioner there. He was brought back to my office at eleven months of age. In the preceding five months he had gained only two and one-half pounds.

The child was never breast fed. A modified evaporated milk formula containing 400 units of vitamin D to the can of milk was used throughout the first year. In addition, the child was started on oleum percomorphum, ten drops a day, at his first office visit at three weeks of age. Orange juice was also started at this time and he has always taken this very well (three to four ounces a day).

He devoloped a cold at four months, which persisted more or less constantly until he was two years of age. After about six months of age he became sickly, had a poor appetite, frequent upper respiratory infections, often complicated by otitis media, and almost constant diarrhea, particularly if coarse foods were taken.

At eleven months the patient was noted to have a moderate rosary, epiphysitis and craniotabes. At this time these findings were not too surprising, in the light of the very bad winter of colds and anorrhexia. It was also thought then, that there might be a slight fat intolerance because of the history of recurrent, though not severe, diarrhea. Oleum perco-

*Figure 1. Both forearms on May 19, 1952, at the time of diagnosis of resistant rickets, and beginning massive therapy.*

*Figure 2. Patient at time of beginning massive therapy.*

morphum was discontinued and a large dose of ABDEC (1.2 cc) was prescribed. It was also suggested that additional sunshine would be of value.

The child did not come back to me until May of 1952, exactly one year after the previous visit. During the second year his mother, who is very conscientious and cooperative, had not missed a day giving two droppersfull of the multivitamins. In October 1951 she consulted another doctor in Orangeburg, who also noted the rickets. This doctor prescribed ten drops a day of "super D". The mother gave the "super" vitamin D in addition to the ABDEC, from October 1951 to May 1952. The child had started walking at about one year of age. However, in October 1951, when he was seen by the doctor in Orangeburg, he was beginning to limp. Therefore, consultation with one of the state's leading orthopedists was advised. Orthopedic shoes were prescribed by this doctor, whereupon the patient stopped walking altogether.

On examination at two years of age the child weighed twenty pounds, thirteen ounces, a gain of exactly one pound in the previous year. At this time the child had obvious, severe rachitic deformities of the head, chest, spine and extremities. He had only eight teeth. The fontanelle was wide open and persistent craniotabes was present. Examination was otherwise not remarkable.

The hemoglobin was 13.8 grams (80%). Urine had a specific gravity of 1.028, was acid, clear and negative for sugar, albumin and calcium (Sulkowitz test) and microscopically. Blood was reported as follows: calcium 8.2, phosphorus 2.8, alkaline phosphatase 6.9 units. X-rays of the long bones showed far advanced rickets with pathological fractures of both ulnae. The bone age was approximately six months.

In spite of the low alkaline phosphatase, which I cannot yet explain, the diagnosis of resistant rickets was made, and the child was started on Infron, 100,000 units orally every three days. Three weeks later the mother stated that his appetite and disposition had greatly improved and that his bowels were normal. He has had no diarrhea since that time. The routine urinalysis was again nega-

*Figure 3. Anterior-posterior and lateral views of left forearm on May 20, 1953. Reported to show complete healing of rachitic process—minimal residual deformities.*

tive, and calcium was absent. Infron was continued, and he was started on 500,000 units of Ertron once a week by intramuscular injection. The mother was given an eight ounce bottle of Sulkowitz reagent, and she has tested his urine for calcium at least once daily since that time.

On June 10th, the Ertron was increased to 1,000,000 units weekly by injection only. On June 24th, the dose was doubled to 1,000,000 units twice a week. On July 8th the mother stated that he was beginning to stand alone, and examination revealed two pre-molars through and the other two coming. On July 22nd, x-rays were repeated and reported to show little, if any, change. Ertron was increased to 1,000,000 units three times a week. On September 3, 1952, the radiologist gave the first encouraging report of definite narrowing of epiphyseal plates. There was still gross cupping. Blood showed calcium 9.0, phosphorus 2.7, alkaline phosphatase 19.8. From October 1952 to January 1953, injections of Ertron were missed occasionally, but the child usually got from one to three million units per week. By January 1953, he was walking very well (with shoes that have internal wedges). He weighed

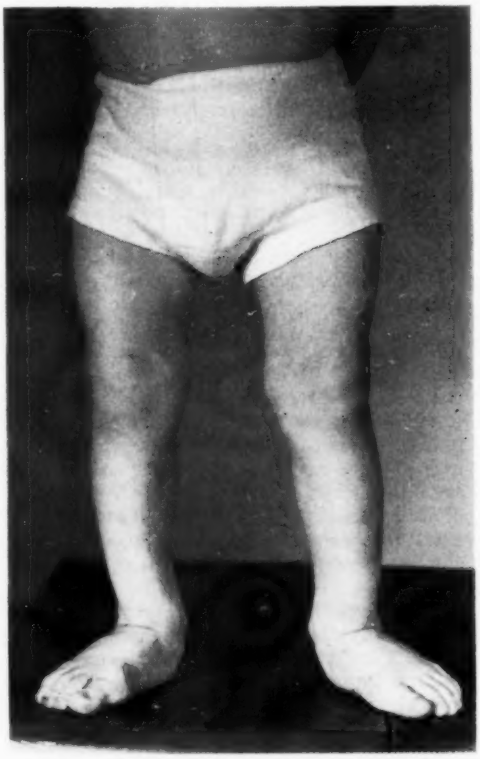

*Figure 4. Photograph of patient in May, 1953.*

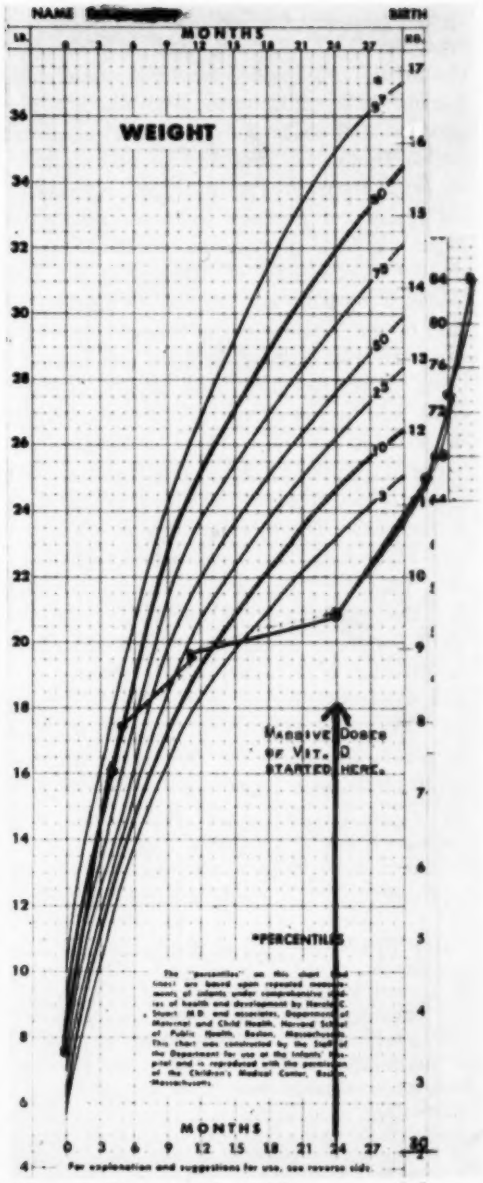


*Figure 5. The patient's weights as recorded on a Whetzel grid, showing better than average weight gain for first five months, almost complete arrest for next 17 months, and then return to previously established channel one year after beginning massive vitamin D therapy.*

twenty four and one-half pounds, and had sixteen teeth. Fontanelle had closed. Blood chemistry remained essentially unchanged: calcium 9.2, phosphorus 4.5, alkaline phosphatase 19.2 units. X-rays showed continuing improvement. On that day he was started on an oral preparation of irradiated ergosterol of extremely high potency* He could not swallow capsules. This preparation contains approximately 50,000 units of vitamin D per drop. Because we were not sure of the standardization of the Ertron, it was thought best to reduce the unit dosages, and he was started on three drops per day. Two months later the dose was increased to four drops or 200,000 units daily.

On March 26, 1953, ten months after beginning massive therapy, calcium first showed up in the urine. The mother stopped giving vitamin D, and the Sulkowitz test showed one to two plus for two weeks before becoming negative again. Two drops a day were then given for three weeks, before calcium showed positive again. Vitamin D was again stopped and the urine cleared in one week. On May 20, 1953, at three years of age, one year after beginning treatment, the child weighed twenty seven and one-half pounds. He is now bright and cooperative. He is said to run all day in "socket-fit" shoes. His appetite is fair. He threw off the few colds he had last winter without difficulty. The blood calcium was 9.6 phosphorus 5.2, and alkaline phosphatase 6.0 units. The radiologists report was "healed rickets with moderate deformities of the long bones."

* This material was supplied to me by Dr. Douglas Remsen of the E. R. Squibb Company, so that we could treat this child without the frequent painful injections.

## SUMMARY

The subject of resistant rickets is presented and defined. A typical case, treated entirely as an office patient, is presented.

The paper was discussed by Dr. Gilbert Forbes, Clinical Associate in Pediatrics, University of Rochester School of Medicine, Rochester, New York. Dr. Forbes stressed the fact that atypical rickets is being seen more frequently every year because ordinary rickets has been practically eliminated by universal use of vitamin D, and the less common forms are seeking clinic-evaluation and being referred. He mentioned that there is one other disease that has recently been described and reported, namely a form of resistant rickets associated with an apparently familial, congenital deficiency of alkaline phosphatase.

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You are to know that there are two broad motives for a man's following medicine: either he loves his kind, and wishes to serve them; or he loves science, and would fain pursue it. There are no other motives which can lead one to distinction among us. You see that in a fashion a doctor must be something of a missionary, something of an idealist, and very much of an enthusiast. He must have breadth of vision, sanity; a mind capable of work without flagging; readiness to accept the new, courage to reject the old; optimism, and a scorn of that crabbed skepticism which glories in entrenched dogma. DOGMA has no place in the vocabulary of science; nor has HERESY. Remember that Voltaire defined a heretic as a man who does not believe as I do. Above all, a doctor must have sound health—during his early years, at least.

James G. Mumford
"A Doctor's Table Talk" 1912

The comparing of experiences, and the balancing of promise against accomplishment, is one of the pleasures of maturity, and sometimes one of its pains. Out of the twenty-four men from my college class, who "went into" medicine, eighteen still write themselves "Doctor." That does not mean that a quarter of our number have forsaken medicine for other callings. Those six men, no longer in our ranks, are either dead or they never matriculated at a medical school. Here is an interesting fact about physicians, a fact unique,—they rarely change their job. You don't hear it said of a man active in the world that he *used to be* a doctor. Physicians sometimes retire, but not for change of business. This is true of no other class of men. Medicine gets a grip which is seldom loosened. It has a fascination all its own. There is a peculiar freemasonry, as there is a peculiar code of ethics, among doctors.

James G. Mumford
"A Doctor's Table Talk" 1912

# *Glaucoma and the General Practitioner*

L. D. Lide, Jr., M. D.
Florence, S. C.

Glaucoma is one of the most common causes of blindness in this country today. It is estimated that 800,000 people have it and that 2 out of every 100 adults over the age of 40 are affected by it. Frequently, it is only after the disease is far advanced and much irreparable destruction of vision has occurred that the patient is seen by the ophthalmologist. Since most of the loss of vision due to glaucoma is permanent, the prognosis is far more favorable if the disease is discovered early. If we are to prevent this blindness, early discovery and institution of treatment and indefinite maintenance of adequate treatment are essential. As in many other diseases, the general practitioner can play a vital role since he is frequently the man who sees the patient first. When the physician develops a high level of suspicion of glaucoma in his patients, more of them will be seen early enough to prevent much of the damage of the disease.

Glaucoma is not a single disease entity. It is present in any eye in which the pressure is too high for that eye. The underlying pathology may be quite varied. Actually the glaucomas are a group of diseases which have in common the outstanding feature of elevated intra-ocular pressure. Fortunately, glaucoma is not very common in children and young people, although it occurs at any age. The older the patient, the more likely he is to have glaucoma. It is relatively rare before the age of thirty-five. It is rather common in Negroes and also rather resistant to treatment in this race.

Glaucoma may be primary or secondary. This discussion will be confined to the much more common primary glaucoma. Primary glaucoma can be divided into acute and chronic types. The chronic can be further subdivided into chronic congestive and chronic simple. A little discussion of the physio-pathology of the disease can be helpful in our understanding of the problems presented. Whenever the pressure in an eye is too high, that pressure is exerted in all directions. Some of the ocular structures are, however, much more susceptible to pressure than others. The loss of vision is due, primarily, to damage from pressure upon the optic nerve and retina. There are two pressure effects. First, that of sudden, acute, severe elevation of pressure, such as is seen in acute congestive glaucoma. This does serious damage in a very short while. Here, the visual loss is due to damage to the retina, probably directly from pressure on the rods and cones or the nerve fibers of the retina, or possibly, indirectly from vascular changes. If this pressure is not relieved in a short time, severe and permanent visual loss can occur. On the other hand, if this pressure is relieved early, there may be a return of vision to normal levels. The second effect of elevated intra-ocular pressure is that of moderately elevated pressure exerted upon the ocular structures over a long period of time. The lamina cribrosa of the optic nerve is the weakest portion of the coats of the eyeball. This gives way first. Excavation or cupping of the optic nerve-head occurs. The nerve fibers are stretched over the sharp margin of the scleral ring. Interference with function and subsequent atrophy occur. Once this damage has been done, most of it is permanent.

The aqueous is produced at a fairly steady rate within the eye by the ciliary processes of the ciliary body. It then finds its way forward through the pupillary space into the anterior chamber. It must flow from the anterior chamber by way of the canal of Schlemm. Guarding the canal of Schelmm is the trabeculum. In the trabeculum there are multiple microscopic spaces through which the aqueous must pass. The drainage angle, at the apex of the angle formed by the iris and the peripheral cornea, is normally hidden from view as one looks at the eye. Some eyes have a shallow anterior chamber where the space between the posterior surface of the cornea and the anterior surface of the iris and lens is rather small and where the angle is narrower or more acute than normal. If the root of the iris should

come in contact with the posterior surface of the cornea, then the trabeculum would be closed off and the out-flow of fluid would be very effectively blocked. Such an eye then has a predisposition to narrow-angle glaucoma. Pressure from behind, forcing the iris forward, or dilatation of the pupil might place the iris in contact with the trabeculum. This is the mechanism in narrow angle glaucoma of which acute congestive glaucoma and chronic congestive glaucoma are examples. Since the entire circumference of the drainage angle may be closed at one time, the pressure may go rapidly to very high levels producing acute congestive glaucoma. If only a portion of the angle is closed off, chronic congestive glaucoma may result. On the other hand, if the anterior chamber is of normal depth and if the drainage angle is wide, an eye may still have glaucoma from obstruction to out-flow due to pathology of the trabeculum or other portions of the drainage apparatus. Among the possible causative factors are sclerosis of the trabeculum, narrowing of the lumen of the aqueous veins, or blocking of the trabecular spaces by pigmentary or cellular debris. If any of these conditions should occur, the out-flow of fluid from the eye would be obstructed and chronic simple glaucoma would be the result.

SIGNS AND SYMPTOMS OF ACUTE CONGESTIVE GLAUCOMA:

The onset is usually quite sudden and may occur in the middle of the night. The condition may be bilateral. The pain in the eye is usually severe, and radiates to involve the whole side of the head. It is a deep pain. The loss of vision is usually severe. This combination of pain and loss of vision is, in the large majority of cases, due to acute glaucoma, Wherever the two occur together, it must be ruled out. As a result of vascular decompensation, the eye is acutely congested and red. The cornea is steamy. The patient may see haloes around lights. It is usually impossible to get a view of the ocular fundus because of the corneal changes. The pupil is moderately dilated and usually irregular in outline. The anterior chamber is shallow. There may be excessive lacrimation and some edema of the lids. The tension is usually very high, between 60 and 100 mm. of mercury. On palpation, the eye feels hard. Nausea and vomiting are frequently present, the result of a reflex by way of the vagus nerve. Oftimes much valuable time is lost while the patient is being treated for a gastro-intestinal condition, when in reality he has glaucoma. Acute congestive glaucoma is an emergency. Every hour of delay in institution of treatment may mean permanent visual loss. Delay of treatment beyond 48 hours may result in total permanent blindness of that eye.

Differential diagnosis of acute congestive glaucoma from acute iritis and from acute conjunctivitis is not always easy. In acute iritis the pupil is usually small and immobile. There is deep circumcorneal congestion. The pain may be severe. The ocular tension is usually normal or subnormal, but it may be elevated, giving the patient a glaucoma secondary to iritis. If a case of glaucoma is confused with iritis and placed on atropine, which is usually used in acute iritis, one can readily see how disastrous the result would be. It is well to point out at this time some of the potential dangers of the use of atropine. The older elementary text-books recommended its use in almost every condition except glaucoma. Later knowledge has shown that this is frequently unwise. The use of atropine in any patient over the age of forty should be undertaken very cautiously. It is not well to use it routinely after the removal of corneal foreign bodies. It has very little place in the treatment of conjunctivitis, even of moderate severity. Actually, there may have been cases where acute congestive glaucoma was brought on by the use of atropine and its derivatives systemically. Since the differential diagnosis between acute glaucoma and acute iritis is frequently quite difficult, treatment of iritis should not be undertaken without careful study and cautious use of drugs. Acute conjunctivitis usually is marked by a more superficial conjunctival congestion. The pupil is mobile, equal, regular and reacts to light. The vision is not usually affected to an appreciable degree nor is the pain deep and severe. One can get a good view of the ocular fundus. In acute conjunctivitis the secretion is usually purulent. If there is any doubt about whether a case is one of conjunctivitis or of glaucoma, don't lose valuable

time on a therapeutic test of antibiotics.

The treatment of acute congestive glaucoma consists first, of intensive miotic therapy. Four percent solution of pilocarpine, 5% solution of prostigmin bromide, 1% solution of physostigmine, or other similar drugs instilled into the eye every 15 minutes for 2 hours, with subsequent decrease in frequency of administration to every 30 minutes may result in a lowering of the tension. If the tension is adequately lowered, no immediate surgery is necessary. Usually within 4 to 8 hours, one can tell what the result of the miotic therapy is going to be. The level of the patient's vision is important in the decision on how long miotics may be tried. If the vision is down to hand movements, delay cannot be tolerated. The patient may experience considerable pain from intensive miotic therapy, but this is not to be confused with that of glaucoma. In a patient with acute congestive glaucoma, if the tension is not relieved, surgery should be done. If the case is only 48 to 72 hours old, or if the tension comes down to normal on miotics, an iridectomy should be done as the operation of choice. A peripheral iridectomy is usually quite adequate. If, on the other hand, the condition has existed longer, one of the filtering operations may be necessary. Or, as Chandler[1] has recommended, one may do an iridectomy and open the angle with a cyclodialysis spatula. In a narrow angle glaucoma, if iris is removed from a peripheral portion of the angle, aqueous can reach the trabeculum and the obstruction may be relieved. As a general rule, any patient who has had acute congestive glaucoma and had the tension relieved by miotic therapy, should not be allowed to leave the hospital before an iridectomy can be done. Once he has had an attack, it is fairly certain that he will have another sooner or later. An iridectomy may prevent it entirely. It is preferable to operate on an eye in which the tension has been lowered and the vascular congestion has subsided. The operative results are better than if the operation has to be done while the tension is elevated.

CHRONIC GLAUCOMA

In contrast to the dramatic, sudden onset with severe pain, marked loss of vision, and redness of the eye of acute congestive glaucoma, there is a marked lack of symptoms in the early stages of chronic glaucoma. Chronic glaucoma may be of the chronic congestive or chronic simple type. The former may be the end result of mild and self-limited attacks of acute congestive glaucoma. It may result whenever the drainage angle is narrow and the drainage outflow is partially obstructed by adhesions between the iris and the trabeculum or the posterior surface of the cornea, adhesions known as peripheral anterior synechiae. The obstruction to outflow may be partial but constant. On the other hand, chronic simple glaucoma has an angle which is wide and the elevated pressure is due to obstruction in the drainage channels. Long continued elevation of intra-ocular tension results in cupping and atrophy of the fibers in the nerve-head. The cupping is usually proportional to the loss of field. In other words, one can predict roughly which portion of the visual fields will show constriction. The field changes of glaucoma usually follow certain characteristic patterns, as some nerve fibers are more susceptible to pressure damage than others. Chronic glaucoma is an insidious disease. Oftentime, the patient does not know he has it. Chronic glaucoma is far more prevalent than acute congestive glaucoma. The prognosis in chronic glaucoma is so much better in cases that are discovered early. In those cases in which the pathologic process is already advanced, the treatment, both medical and surgical is nothing like as effective. Even in spite of apparently adequate lowering of the tension, further loss of vision may occur. It is as if the pathologic process, once instituted, progresses in spite of treatment. It is well to remember also, that some cases of chronic glaucoma, since it is a degenerative disease, will progress in spite of all therapy.

SIGNS AND SYMPTOMS:

Besides elevated tension, which is as a rule, mildly or moderately elevated to perhaps 35 m.m. the first sign is usually loss of peripheral vision. At first this can only be picked up by detailed visual field studies. Central visual acuity is usually not affected at first. Cupping of the optic nerve occurs later. Subjective loss of peripheral vision and ophthalmoscopic evidence of cupping of the nerve-heads are

late signs. As the disease progresses, the peripheral fields may be lost to the point where the patient may have only gun-barrel vision. In time, even this island of sight may be lost. Occasionally one sees a patient with reasonably good visual acuity and yet because of the loss of visual fields, he is industrially blind. He can't see to get about without stumbling over everything. Once this loss of field of vision has occurred, it is for all practical purposes permanent. Usually these patients have such a mild elevation of tension that it can not be picked up on palpation by the average physician. Taking the tension with the tonometer is essential. Confrontation fields are totally unreliable because, for this test to be positive, the loss of field has to be profound. It may be well to mention here, that tactile tension, while extremely useful and important has to be checked frequently by the tonometer. The average ophthalmologist takes tactile tension on practically every patient he sees. If there is the slightest doubt in his mind about the tension of the eye being near borderline, it must be checked by the tonometer. It is amazing how widely ones fingers can vary in their interpretation of the tension within an eye. If the tactile impression is not frequently checked by the tonometer, it can get far away from the actual levels.

TREATMENT:

The treatment of chronic glaucoma consists, first of all, in advising the patient of the presence of the disease and of the necessity for treatment and of the prognosis. A trial of miotic therapy comes first. It may be necessary at first to see the patient every few days for a number of weeks. The desired result is to find the miotic of the lowest strength which will maintain the patient's tension at normal levels. This may vary considerably in different patients. A miotic which at first will be effective may later be ineffective. Increase in the concentration of the drug or change to another may be necessary. Frequent field studies are essential. At first we need to get a clear picture of the visual field loss and more than one charting is necessary to establish this. Subsequent field studies are necessary to detect any further loss of visual field, because continued loss of field is a strong indication for surgical intervention. Decision as to whether surgery will be necessary depends primarily upon the state of the ocular tension, the state of the visual field and any progressive loss, and the age of the patient. Surgical treatment may take one of several forms of filtering operations. In chronic glaucoma, an iris inclusion operation may be done in which a wick of iris is pulled out into the corneoscleral incision, thus permitting aqueous to drain into the sub-conjunctival space for subsequent absorption. Or, one may do a cyclodialysis in which a cleft is made between the ciliary body and the sclera, thus allowing the aqueous to drain into the suprachoroidal space and there be absorbed by the abundant vascular channels in this area. On the other hand, a different approach to the problem may be necessary, if efforts to increase the drainage from the eye are not adequate. One may take steps to decrease the production of aqueous within the eye. This is done by electro-diathermy coagulation of the ciliary body. Subsequently, atrophy of portions of the ciliary processes result and there is a decrease in the production of aqueous. This operation may become necessary, particularily in the more advanced cases.

Glaucoma operations may have to be repeated or new ones done to bring the disease under control. If the intra-ocular pressure remains too high, loss of sight is bound to result. In doing glaucoma surgery, one has to proceed cautiously so that enough will be done without too much being done. It is well to mention here that it takes a great deal of courage to do glaucoma surgery. With the realization of the inevitable loss of vision and ultimate blindness which faces the patient, the ophthalmologist may have to advise surgery at a time when the patient's vision has not yet been seriously affected.

The general practitioner can be of great assistance to the ophthalmologist in affirming to his patient the necessity for his use of miotics. Instillation of drops in the eye has to become a very regular habit with the patient. Use of these drugs day in and day out is necessary, as a rule, for the balance of the patient's natural life, or until surgical intervention becomes necessary. The family physician can also help a great deal in advising his patient

about surgery and the necessity at times for repeated surgery.

PROGNOSIS:

As to prognosis, the most favorable cases are those found in the course of routine eye examination. Usually the patient comes in merely asking for a change in glasses. On examination the pressure is found elevated. Visual field changes are minimal, if present. This is one strong reason for advising the patient over forty to have a thorough eye examination at least every two years and in some cases every year, whether he has any symptoms or not. Far too many patients with chronic glaucoma do not reach the ophthalmologist until the vision of one eye is totally gone and that of the other very seriously impaired. These are the tragedies. Occasionally, one sees a patient who is blind in both eyes, and who was thinking that he probably had cataract which could be cured by surgery whenever he got up courage enough to have it done. Many laymen have the idea that all serious visual losses are due to cataract and can be corrected with surgery. They don't realize that the loss of vision due to glaucoma is irreparable. It is disturbing to see such tragic cases in which the patient is partially blind, when the condition could probably have been prevented. Often the patient will tell you that he has had his glasses changed in the past year or two by a non-medical refractionist. The use of a tonometer is essential to diagnose early chronic glaucoma. Any patient, particularly those in the forty-or-over age group, who complains of seeing haloes around lights, intermittent blurring of vision, failing vision, loss of peripheral field and any other vague complaints about his seeing, should have a comprehensive eye examination to rule out glaucoma.

Still another type of primary glaucoma is congenital glaucoma. In many cases the underlying pathology in congenital glaucoma is a failure of the mesodermal tissue, normally in the drainage angle, to absorb before birth. There results an obstruction to the outflow of fluid from the eye. Increased intra-ocular pressure is the result. In the infant or young child, the coats of the eye are relatively elastic. There may be stretching of the globe from elevation of pressure over a period of time. Stretching of the cornea may result in much enlargement of the cornea, increasing its curvature, and causing breaks in Descemet's membrane which lead to scarring and subsequent disturbance of vision. If the condition exists longer, the whole eyeball may become very muchly stretched and enlarged, resulting in buphthalmos or so-called "ox eye." Of course, cupping of the optic nerve likewise occurs. Congenital glaucoma requires early treatment. The treatment is at best, very difficult and often unsuccessful. At present, goniotomy, which is an operation that consists of going in with a special knife and cutting some of the mesodermal tissue left in the angle, seems to be the operation that gives the most favorable results. The family physician may discover these cases of congenital glaucoma because of steaminess of the cornea or enlargement of the eye, or poor vision.

To summarize: Glaucoma is a serious cause of blindness. It is usually insidious and the damage done is permanent. Early institution of treatment can prevent much of this tragic blindness.

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# *Gonococcal Urethritis with Bacteremia*

## REPORT OF A CASE

ROY A. HOWELL, JR., M. D., STACY H. STORY, M. D. AND REBIE HOLT, B. S.*

Acute gonococcal urethritis is usually unaccompanied by generalized symptoms.[1] That the gonococcus does at times enter the blood stream is evident from the frequency of arthritis, meningitis and endocarditis. However, the organism does not thrive in the blood, as attested to by the infrequency of gonococcal septicemia. Especially since the advent of penicillin has gonococcal septicemia become a rarity and reports of this disease have in recent years been very few.[2,3] Most of the reported cases of gonococcal septicemia occurred before the use of the sulfonamides and penicillin and were characterized by a relatively prolonged course of fever, joint manifestations and skin rashes, not unlike meningococcemia.[4] The death rate was high, but recovery was not unusual, in contrast to the cases with endocarditis.

We wish to report an unusual case of gonococcal urethritis accompanied by bacteremia and certain of the signs and symptoms of a septicemia.

### Report of a Case

F. W., a twenty three year old negro male laborer, was admitted to the medical service of Roper Hospital on August 8, 1952, with the chief complaints of fever and weakness of seven hours' duration. The patient had been in good health until the morning of admission when he noted marked malaise and weakness, anorexia, nausea and headache. He developed high fever accompanied by chilly sensations and pain in both legs. He remained in bed all morning and, on getting up to get a glass of water, fainted, remaining unconscious for several minutes. Upon awakening, he was taken to the hospital.

The patient had noted some dysuria and double voiding for several days prior to admission but he denied ever having had a urethral discharge. He had had intercourse several times during the previous month, but was reluctant to give details. Three weeks prior to the onset of his present difficulty he had an episode of fever and headache which subsided promptly after he was given an injection by a local physician. His past history was otherwise non-contributory.

Physical examination revealed a well developed and well nourished young negro male who appeared acutely and severely ill. The temperature was 104° (F.), pulse 108 per minute, respirations 20 per minute and blood pressure 110/70. The skin was dry and very hot; no rash was seen. The pharynx was slightly injected. There was some resistance to flexion of the neck but no definite rigidity. The lungs were clear. The heart was not enlarged, the rhythm was regular and no murmurs were heard. The abdomen was flat, soft and non-tender, and no organs or masses were palpable. There was a profuse, purulent urethral discharge. Rectal examination was negative; the prostate felt normal.

The leucocyte count was 20,800, with 83% polymorphs, 14% lymphocytes and 3% monocytes. The erythrocyte count was 4.3 million and the hemoglobin 13 gm. %. The urine (voided) was cloudy, specific gravity, 1.020; no sugar, albumin or acetone was present; microscopic examination revealed 40 to 50 pus cells per high power field .The blood Wassermann and Kline were negative. The blood urea nitrogen was 16 mg. per 100 cc.

A culture and a Gram stain were made from the urethral discharge and the latter revealed gram negative intracellular diplococci. A blood culture was drawn and the patient was started on intramuscular aqueous penicillin, 300,000 units initially and 100,000 units every three hours. Within 12 hours the temperature had fallen to 100° F. and the patient was feeling much better. By the next day he was afebrile and much improved. He became asymptomatic except for some residual weakness and malaise. The urethral discharge cleared. Penicillin was continued for three days to a total dose of 2.6 million units.

The culture of the urethral pus and the

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blood culture both grew gram negative diplococci which were identified morphologically, culturally and by fermentation reactions to be neisseria gonorrhoeae. The patient remained asymptomatic and was discharged on August 28, 1952.

### Comments and Summary

This patient presented the picture of a severe acute infection with marked toxic symptoms. Had it not been for the presence of the urethral discharge, prompt diagnosis would have been difficult. Culture of both the urethral pus and the blood grew out neisseria gonorrhoeae. The patient was extremely ill on admission to the hospital but response to penicillin was prompt and dramatic.

Current concepts of treatment of gonorrhea emphasize the "one-shot" method, using 300,000 to 600,000 units of long-acting penicillin, which results in the cure of about 90% of the cases.[5] It is important to keep in mind, however, that a few cases are not cured with this dosage.[6] It is also important to remember that blood stream invasion does occur and may give rise to serious complications. For these reasons, all patients with gonorrhea should be questioned and examined carefully before treatment is begun and should return for follow up. In cases with fever or generalized symptoms, larger doses of penicillin than usually employed, preferably in the aqueous form, should be used.

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## Pathological Conference, Medical College of South Carolina

Dr. Abram Berry: Mr. Johnson, will you present the protocol on today's conference.

Mr. R. M. Johnson: *PRESENT ILLNESS*: Patient is a newborn colored female who was born spontaneously on June 13, 1952, after gestation of 7 months. The infant did not breathe at first (5-8 minutes), but suction with artificial respiration was applied with good results. Physical Examination: Weight—3 lbs. 2 oz.; fair color and activity; lungs relatively poorly aerated, with rales throughout, and much mucous secretion. Cough reflex active; marked talipes equinovarus of left foot; supernumerary digit present on left hand; heart rate was regular; general condition poor.

*HOSPITAL COURSE*: The infant was placed immediately in an incubator, was given routine premature therapy, and put on penicillin. June 14: lungs poorly aerated; color satisfactory; temperature ranging in 99s; formula begun. June 15: Left lung shows decreased breath sounds; baby taking small amounts of fluids; clysis given (Hartman's). Temperature here began to assume the spiking character which prevailed during remainder of hospital course. June 17: Anemia noted; received 30 cc whole blood intravenously, and 100 cc Hartman's by clysis; slight icterus of skin noted before transfusion; lungs slightly better aerated. June 22: Progressive weight loss to 2 lbs. 8½ ozs. noted; polyethylene tube passed for feeding purposes. June 26: Some atelectasis persists; pallor present, given 30 cc blood by intravenous push. June 27: First severe episode of (?) aspiration with cessation of breathing and fairly marked cyanosis following feeding; two milder episodes had been noted by the nurse previously, the first on June 19. Following the episode of June 27, even after caffeine, artificial respiration and $O_2$, infant had gasping respiration for some time, with suction later productive of large amount of greenish-brown material. The remainder of the infant's course was characterized by intermittent episodes of a similar nature to the above, with gradually increasing frequency and severity; each time there was cyanosis and cessation of respiration, either immediately after feeding or within 15-20 minutes after feeding; each time the infant responded to oxygen, caffeine, and artificial respiration with suction, returning to good color and

respiration within a few minutes. Ordinary vomiting or aspiration did not precede many of these episodes, according to one resident's notes, (although one episode was noted to be preceded by vomiting.) Often there was no coughing; the lungs were noted to be full of rales, with dullness in left lower lobe, at least one time; aeration was noted on both sides, however. Suction obtained mucus or milk each time, apparently from the naso-pharynx; ashen color was often noted upon removal from the isolette.

Anemia was noted several times, and the infant was transfused with 32-40 cc of blood five times. High temperatures were treated with ice bag in isolette and Terramycin was given. Apparently normal yellow stools noted throughout, somewhat less than usual in number. Infant maintained average weight of 2 lbs. 9 ozs. until June 29, then gradually gained to 4 lbs. 5 ozs. at time of demise. On July 28, patient had final episode of cyanosis and cessation of respiration; there was no feeding prior to this episode; apnea did not respond to caffeine this time, neither intramuscular nor intracardiac; artificial respiration failed to give benefit; Cheyne-Stokes respiration had been noted by nurses three hours previously. Heart beat had ceased before resident arrived, and infant could not be revived.

*LABORATORY DATA*: June 17: RBC 3.98, HGB 11.5

July 8: RBC 2.18; HGB 7.5

July 12: RBC 5.12; HGB 11.5; WBC 10,450; PMN 49; L 43; M 5; E 3

July 18: RBC 4.18; HGB 9.5; WBC 11,050; PMN 65; L 28; M 2; E 5

July 25: RBC 3.00; HGB 9.25; WBC 4,000; PMN 20; L 80.

Dr. Berry: Mr. Stanley, will you discuss this case?

Mr. J. H. Stanley: I think the first thing we have to consider is that this infant did not breathe for 5-8 minutes after birth, but considering the absence of any difficulty for several days after respiration was established and the absence of any neurological signs she must have recovered from this initial insult.

On the 14th we see that the lungs were poorly aerated and on the 15th the left lung showed decreased breath sounds. On this same day her temperature began spiking; so I think we can say she probably aspirated something and had pneumonia. Her temperature continued to spike throughout her life and I believe she had pneumonia all the time in spite of antibiotics.

Then on the 17th, or the 4th day of life, an anemia was noted and 30 cc of whole blood given. At this time a slight icterus of the skin was also noted. Because this occurred on the 4th day of life it appears to be nothing more than physiological icterus of the newborn rather than erythroblastosis fetalis, which should appear earlier, or something like atresia of the bile ducts, which should produce signs later.

Dr. Berry: Wasn't there enough, otherwise, to explain this anemia?

Mr. Stanley: Yes sir, I think just prematurity and inability of the hemopoietic system to respond is the best explanation for it.

Then on the 22nd we see that the infant had had progressive weight loss and a tube was passed for feeding. Then 4 days later the tube was removed; so in this time she must have gained adequate strength and developed a good enough sucking reflex to use a bottle. On the same day pallor was noted and 30 cc more of whole blood was given.

Then on the 27th, or the 14th day of life, she had the first severe episode of aspiration ("questionable") with cessation of breathing and cyanosis—this had been preceeded by two milder episodes. With just this one episode I don't think we can say what its cause was, but considering the character of the episodes which followed through the next month until her death several things are suggested.

Diaphragmatic hernia might give this picture. Not absence of one diaphragmatic leaf but one which would develope slowly with a true hernia sac like you might get through the canal of Bochdalek or the foramen of Morgagni. These might develope after several days of handling—with pressure on the abdomen. One thing against this is that no peristaltic waves were heard over the chest and no x-rays were taken which, I am sure, would have been done if this condition had been suggested.

Vascular rings can give episodes of apnea and cyanosis but not like the ones she had.

Mr. Stanley: No sir. These attacks occurred after feeding—usually 15-20 minutes afterwards—and with a vascular ring I would expect the attack of apnea and cyanosis to appear during feeding, even with the first few swallows, because these episodes are supposed to be caused by a bolus of food passing down the esophagus. (Note that attacks frequently were immediately after eating—Ed.)

Then we have to consider tracheo-esophageal fistulas.

Dr. Berry: Is the usual type of tracheo-esophageal fistula compatible with her life span?

Mr. Stanley: No sir, not the most common type, but the most uncommon type is.

Dr. Berry: What is the most common type?

Mr. Stanley: It's the type in which the esophagus ends in a blind pouch. There is also a segment above the stomach which connects with the trachea.

Dr. Berry: Would passing a tube help rule out tracheo-esophageal fistula?

Mr. Stanley: It would help rule out all except the most uncommon type which is the "H" type. This type is patent to the stomach but also connects with the trachea.

Dr. Berry: Do you think this patient had an "H" type esophago-tracheal fistula? How could you rule it out?

Mr. Stanley: No sir, it should have given trouble earlier—with the first feeding or so. The only way I know to rule it out definitely is by lipiodol studies, but she just didn't have enough trouble early enough and after every feeding to rule it in.

Tracheal tumors have to be considered—papillomas,

fibromas and angiomas, but these can't be ruled in or out definitely.

Then, mediastinal cysts could give this picture. Bronchogenic cysts may cause symptoms early, but they are most apt to appear later. Gastric cysts may be located behind the pleura and they usually cause symptoms early—but I didn't think much about these.

Dr. Berry: What else did you consider?

Mr. Stanley: If you want to consider the club foot as a congenital anomaly along with the extra digit on the left hand and speculate on other hidden congenital defects being present you might consider Fanconi's syndrome.

Dr. Berry: And what else?

Mr. Stanley: I don't think hyaline membrane is compatible with her life span of about 6 weeks. You might think about some materials being present which she aspirated before or during birth and just never was able to get rid of. I think congenital cystic disease of the lungs must be considered, but this doesn't usually cause trouble referable to the respiratory system until later in life.

One must think also of congenital heart disease which might give episodes similar to those that she had.

Dr. Berry: Do you think she had congenital heart disease? She had other defects—why not speculate on some being present in the heart?

Mr. Stanley: I don't think she had congenital heart disease but I can't rule it out. This dullness in the left lung might have been due to an enlarged heart resulting from some congenital defect but no murmur was present. This would rule out some defects. Some of this weight gain starting on the 16th day of life could have been edema but that's just a guess and I couldn't back up any heart defect with it.

Dr. Berry: Mr. Williams, what is your opinion concerning this patient? Give the differential diagnosis, most likely diagnosis, and cause of death.

Mr. Julian Williams: My diagnosis agrees with the one suggested by Mr. Stanley, "vascular ring obstructing esophagus with aspiration pneumonia."

The condition of "vascular rings" occurs by the persistance of both arches of the aorta; thus, encircling the trachea and the esophagus producing symptoms of difficulty in swallowing and in breathing. The clinical symptoms of dysphagia, croupy cough, laryngeal stridor and cyanosis are due to pressure on the trachea.

In this case we note that the first mild episode of aspiration and cyanosis occurred on June 19, 6 days after delivery, with severe cyanosis and with aspiration on June 27. No history of coughing or laryngeal stridor was given.

With the symptoms in this case I first thought of tracheo-esophageal fistula; however, this can be ruled out on the absence of regurgitation for the first 6 days. Some must have occurred anyway to produce the pneumonia. The most common type, 80-90%, of the upper blind esophageal pouch can certainly be ruled out. The most likely type would be the one with a fistula between both open esophagus and trachea; however, you would expect more severe symptoms earlier.

We may definitely diagnose pneumonia on the basis of poorly aerated lungs, temperature in 99's and spiking and decreased breath sounds, basing it all on an aspiration type of pneumonia. The cause of death, I attribute to aspiration pneumonia which the infant was unable to combat due to prematurity and to malnutrition.

The aspiration pneumonia is quite typical, with a possible history of intra-uterine fetal embarrasement, difficult resuscitation at birth, cyanosis, and respiratory distress, much mucous secretion, crepitant rales, and consolidation in areas of the lungs.

We also know that congenital anomalies are often present in numbers. The marked talipes equinovarus of the left foot and supernumerary digit on the left hand, with suspicion of some congenital condition causing clinical symptoms, make us consider the possibility of other anomalies. Congenital conditions which I think should be considered are short esophagus which I cannot rule out; congenital stenosis which is asymptomatic until solids are eaten; neurogenic lesions; and congenital hypertrophic pyloric stenosis.

Dr. Berry: How do you account for the anemia?

Mr. Williams: Again, I agree with Mr. Stanley that the anemia is insignificant in that it is relatively common in the premature infant and only begins to rise to normal values about the 12th week of age.

Dr. Berry: What are the types of congenital heart disease associated with cyanosis?

Mr. Williams: For cyanosis the condition must be such as to permit a right to left shunt of blood. This may occur at times in patent ductus (potential) and occurs in tetralogy of Fallot and in rudimentary right ventricle. We have no persistance of cyanosis here, but an intermittant type occurring immediately after or 15-20 minutes after feedings.

In conclusion, I think it very difficult to attribute the regurgitation and cyanosis to one specific thing; however, the most likely cause is a vascular ring. Aspiration pneumonia is the most likely cause of death.

Dr. Berry: Mr. Ackerman, what can you add to this discussion?

Mr. R. E. Ackerman: I think that, in the case of a premature infant who was anoxic for five to eight minutes after delivery, cerebral anoxia should be considered a definite possibility. This could result in petechial hemorrhages with later patchy areas of cortical atrophy. On this basis, the patient might have had damage to the respiratory center as well as to the temperature regulating mechanism, and this could account for the entire clinical picture.

I think, however, that this is probably simply the case of a premature infant who developed an aspiration penumonia, with death primarily on this basis.

Another anomaly, however, which must be considered is that of the left coronary artery's arising

from the pulmonary artery rather than the aorta.

Mr. Ackerman: I think a vascular ring is a possibility, but I think that one would expect tracheal compression with a stridor, and this patient had no stridor. I think that a right aortic arch passing behind the esophagus with pressure on the esophagus resulting in regurgitation and aspiration of food with a resultant aspiration pneumonia is a possibility.

Dr. Berry: Does a right aortic arch ordinarily pass behind the esophagus?

Mr. Ackerman: No sir, I think it usually passes in front of the esophagus.

*Figure I. The aberrant right subclavian artery (2) compresses and distorts the esophagus (1).*

Dr. F. E. Kredel: While, on first reading of the protocol, I was inclined to consider the possibility of a lateral or "H" type of trachea-esophageal fistula, the delayed regurgitation fits esophageal obstruction better. Since congenital anomalies of the hand and foot are noted, one must think of a congenital lesion obstructing the esophagus, such as a vascular ring.

Dr. Berry: I should like to point out that this child was never in good enough condition to risk sending down to x-ray, consequently the exact diagnosis was never made clinically. I will call on the pathologists to give us their findings.

Dr. Forde A. McIver: The final pathological diagnoses in today's case included:

(1) ANOMALOUS RIGHT SUBCLAVIAN ARTERY

(2) CHRONIC PNEUMONITIS, PROBABLY ASPIRATORY

(3) IMMATURITY

*Figure II. The aberrant right subclavian artery (2) arises from the posteromedial wall of the aortic arch and passes behind the esophagus (1).*

These pictures (Figs. I and II) show how the aberrant artery caused difficulty. You see that it arises from the arch of the aorta just distal to the left subclavian artery and passes to the right side behind the esophagus and trachea. Compression of the esophagus is clearly demonstrated and no doubt resulted in repeated regurgitation and aspiration of secretions and formula. These intermittent respiratory insults produced a pneumonia which presents some features of lipoid pneumonia and others suggesting pneumonia of an interstitial type. In any case, pneumonia of this degree, together with immaturity, explain this child's clinical course and death.

It should be pointed out that, after coarctation and patent ductus arteriosus, an aberrant right subclavian artery is the most common anomaly of the aortic arch. It is explained, embryologically, on the basis of obliteration of the right fourth aortic arch and persistence of the right dorsal aorta. This condition is a great deal more common than the double aortic arch ("vascular ring") mentioned in today's discussion. Yet, it is true that an aberrant right subclavian artery may, and frequently does, persist for many years without producing symptoms. In later life, as the vascular system becomes less pliable, difficulty in swallowing may appear for the first time. Such a chain of events has been referred to in the past as "dysphagia lusoria"—a swallowing difficulty due to one of nature's practical jokes. The early and severe symptoms in this case may, perhaps, be explained by the smallness of the immature child and the exceptionally large aberrant vessel.

Had the condition of this patient permitted necessary diagnostic studies, ligation and division of the aberrant vessel should have produced a dramatic relief of symptoms.

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## THE PHYSICIAN AND VOLUNTARY HEALTH INSURANCE

Voluntary health insurance has assumed such large proportions in the last few years that it is now an important factor in the private practice of medicine. Not long ago it was the exceptional patient who had such coverage, while now it is so generally held there is hardly a physician who does not have to devote several hours a week to filling out insurance forms, besides providing additional secretarial help for this purpose. It is the means by which the citizen of moderate income can maintain his status as a private patient and accordingly have some choice as to physician and hospital. Furthermore it is a strong bulwark against the ever present threat of the complete socialization of medicine.

To continue on a sound basis, voluntary health insurance must be protected from abuses. In this respect physicians can play an important part. It is their moral obligation, as well as it is to their advantage, to do so. No company can survive on reasonable premium rates if it is called upon to pay for costly illnesses and operations which are anticipated by the insured at the time of taking out the policy. Upon learning that an operation is advisable, patients have been known to take out insurance and to change doctors so as to present a false claim as to dates. In stating dates concerning the onset and duration of illnesses the physician should be particularly careful to ascertain the facts and to adhere to the truth; the same applies to etiology. In some cases where the attending physician cannot be certain of the facts it may be advisable to refer such matters to the family physician. A common abuse is to admit a patient to a hospital for a particular condition and to order a lot of expensive diagnostic work not relevant to the illness for which the patient is being treated. The physician should not be a party to hospitalizing a patient at the expense of the insurance company to save the patient the cost of a minor operation which could be done on an out-patient basis. The same principle applies to keeping the patient in the hospital unnecessarily long.

Abuses of this type can only result in such increase in premium rates as to defeat the purpose of a sound insurance program. Physicians should exert their efforts to prevent them, though at the time it is difficult to refuse a patient what appears to be a reasonable request. In the long run it is to their advantage to do so, though in some cases it may cost them something in the loss of fees, and at times the loss of patients.

On the other hand there are instances in which patients should be protected from insurance companies. Some clauses relative to time of onset and etiology are so worded as to absolve the insurance company from any reasonable claim. A patient may have had a goitre or gall stones of many years duration though not have a suspicion of their presence at the time of taking out the insurance policy. In such cases it seems reasonable and fair that the illness should be dated from the time that the patient's health is affected or that symptoms appear rather than that of the formation of the gall stones or the beginning of the goitre. Insurance companies should recognize claims of this type and not search the hospital records for a way of escaping responsibility.

Most physicians try to fill out insurance forms honestly and correctly, but in many instances are handicapped by the complexity of the forms and the number of questions irrelevant to the particular case. A reform along this line is very much needed. A great many problems would be resolved if the effectiveness of the policy were based upon a specific date rather than the time of onset and the etiology of the disease. To complete some of the insurance forms would require the wisdom of a Solomon. The physician does not wish to assume such a role.

William H. Prioleau

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**DOCTORS HELP INCREASE THE COST OF HEALTH INSURANCE**

Physicians, taken as a whole, are honorable men of high integrity. This is especially true in South Carolina where doctors know or know of almost every other doctor. Sometimes, though, we have a blind spot where insurance companies are involved. Utilization of health insurance all over the nation has risen since World War II. The rate for the nation is 130 per thousand subscribers. In South Carolina the rate is 166 per thousand subscribers. Health insurance is for the sick and should be used only for that.

In South Carolina last year if the Blue Cross Plan had had 5 fewer admissions per month per hospital it would have saved $250,000.00. If each patient's stay in the hospital had been reduced by one half day an increase in rates would not have been necessary. Obstetrical patients now leave the hospital in from three to five days whereas two weeks used to be standard. Herniorrhaphy and appendectomy no longer require a long stay in the hospital. Respiratory infections usually are cured in three or four days. Intractable vomiting associated with gastroenteritus usually responds to a clysis or intravenous in the office or emergency room and further treatment at home.

With a little thought and good management doctors can shorten a patient's stay in the hospital or prevent it altogether. Certainly a person with insurance is entitled to receive everything that the policy provides for if *those procedures are indicated* and that is where the rub comes. Hospitalization is indicated because of sickness, not because of insurance, regardless of the pressure brought to bear by the patient.

Every automobile accident makes our automobile insurance higher. Every fire makes our fire insurance rate higher, every theft or burglary, every malpractice suit our malpractice insurance higher and so on. The patient, not the insurance company, will have to pay for greater and longer utilization. If we as doctors can save our patients money, there will be more money to pay the doctor, that's you and me. There are three major reasons for shortening the stay or avoiding admission to a hospital. First: it's right and fair; second: it helps the patient in the long run in his premiums; and, third: anything that helps our patients helps you and me.

G. D. Johnson

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The Journal of the South Carolina Medical Association

# Forty Years Ago

March 1914

Florence, meeting place of the Association, was described in an extensive article, garnished with "soft sunlight splashing the forests . . . and . . . the enchanting music of the mocking bird"—In the photographs no single automobile mars the streets of the business district. Dr. John Townsend of Charleston was to read a paper, as was Dr. R. M. Pollitzer, then likewise of Charleston. Dr. J. H. Gibbes of Columbia was to speak on Chronic Infections. Dr. Paul Switzer was welcomed to the Union County Society.

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**AMERICAN MEDICAL EDUCATION FOUNDATION**

The American Medical Education Foundation and the National Fund for Medical Education are entering their fourth year of operation. In the three years of existence, $4,764,-152.79 has been distributed to the medical schools of this country.

In the consideration of such figures one must

admit that these agencies are going concerns. However, there appear to be misconceptions as to how this money is derived and on what basis it is distributed. The funds of the National Fund for Medical Education come from two sources: (1) The American Medical Education Foundation, which is supported by the American Medical Association and has derived its income from physicians alone; and (2) by direct solicitation from industry.

When industry was originally approached by interested persons to solicit their support of medical education, it was pointed out to them that the medical schools of this country were in dire straits. The cost of medical education had risen apace and it was obvious that additional support must come from some source, either from private resources or government subsidy. Fearing the inroads of government subsidy, the National Fund was formulated to enlist the assistance of industry. The work of this group is of such statue that they were incorporated by special act of Congress. The first question asked of them was "What are the doctors themselves doing about it?" This is now answered by the fact that the American Medical Education Foundation has turned over to the National Fund for distribution to date $2,462,304.78.

This is a good beginning but, in spite of the astronomical appearance of these figures, it is not enough when it is considered that the 79 approved schools of medicine in the United States train approximately 27,000 undergraduates and 55,000 other medical scientists taking postgraduate work. They graduate more than 6,000 doctors annually, 1,000 more than a decade ago, but not enough to keep pace with the ever-increasing demand. Strong, self-reliant, well-staffed medical schools are a keystone of the national welfare. It would be tragic indeed if the activities of our medical schools were curtailed.

Today it is estimated that $5,000,000.00 is needed to meet urgent medical school problems. Another $5,000,000.00 is needed to overcome equally pressing long range problems. The average cost of training a doctor has doubled in 20 years to $10,000.00. Many schools have raised their tuition since 1940, but this is only a small portion of the increase which is needed to meet the rising cost of medical education. There is grave risk that research activities and scientific advance will be stultified by lack of personnel in full-time medical college positions.

The goal for the National Fund for Medical Education for 1954 is $10,000,000.00. The American Medical Education Foundation has accepted the problem of a goal of $2,000,000.00 from physicians. In order to meet this goal it will require at least a $10.00 contribution by every practicing physician in this country.

As an opening and in order to show its endorsement, the Medical Association of South Carolina voted $10,000.00 to be placed in this fund. Since that time (1951) South Carolina has depended on voluntary contributions which have been extremely disappointing. In that first year, by reason of the $10,000.00, South Carolina ranked third among the states in the support of this effort. However, in the year 1953, South Carolina's position was second from the bottom. This is in spite of the fact that our Association vigorously supported this movement at its beginning.

It is to be pointed out that contributions need not be of large sums, although of course it is desirable, but small contributions are gratefully received.

In order that a physician may display his loyalty to his own school, he may, if he desires, earmark the money that he contributes to the support of his own school or any school of his choice.

It is repeatedly emphasized by the administrators of both of these funds that none of the money contributed by physicians is used for administrative purposes at all. The American Medical Association supports the expenses incurred by the American Medical Education Foundation and none of the money contributed by doctors goes to any other purpose than the support of medical schools. The fund accumulated by subscriptions not earmarked is apportioned to the 79 medical schools on an equal basis, the two year schools having half of that of the four year schools. In addition, money is prorated on an enrollment basis.

The money, after distribution to the medical school, has no restrictions placed upon it. The

administration of the medical school can use this money for any purpose which it desires and by this token it is invaluable.

Donations to medical education are undoubtedly a worthwhile project. It would be well if every physician in the United States determined that he was going to use the American Medical Education Foundation as one of his income tax deduction avenues. The address is: 535 N. Dearborn Street, Chicago 10, Illinois.

J. T. C.

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# *Omnia in Risu*

## IT'S ALL IN FUN

When Joe Waring said to me, "Boy, you ought to do something for the profession that has made you what you are—little as you may be." I thought, "What can I do to help medicine out of this terrible mess it's in." The answer coming back via several of my professional colleagues was unanimously, "NUTHING." However, I did feel that with the help of some of my more enlightened colleagues (who would give me some active reading material) I could make "Omnia in Risu" worthwhile and presentable.

Now, I suppose that all of us have met or even worse are intimately associated at times with a colleague who might fit in the following story.

The bridegroom, Rastus, with his bride showed up at the office of the Justice of the Peace asking him to tie the long lasting and eternal knot. The old justice sitting from his seat of Local Law looked over the license and said, "This license doesn't have the date on it; you will have to take it over to the clerk of court and have that fixed." "Jedge," Rastus said, "You know the date; can't you just put it in and go ahead and marry us?" "Oh, no," replied the judge "You will have to go back to the Town Hall and get it fixed." Back went Rastus and his near bride, up to the town clerk who affixed the date and back to the Judge.

The old justice looked it over. "H'm," he h'med, "It looks like the clerk forgot to put in your girl's maiden name. Take it back over to the clerk of court and have him fix it." But, the anxious bridegroom pleaded, "The Town Hall is all closed up and the clerk has gone home, can't you put her name in for us?" In all his judicial dignity, the old Judge said, "Now look here, son, I don't go around tampering with legal papers—you go right back and have that clerk of court fix the papers properly."

Over to the Town Hall rushes Rastus and the Frantic Lady of his life. They finally catch the clerk who makes the necessary additions and back to the Judge they go.

After finally satisfying himself that things were in good order the kind old Judge pronounced Rastus and his bride, Man and Wife. Then for the first time, the Judge noticed the four-year old boy in the room. "Whose child is that?" "Ours, Judge," Rastus replied. Somewhat taken aback, the Judge asked, "You mean . . you had the child before---?" "Yes," said Rastus, "before we were married."

"Well," the old man said, "Of course you're married now but you must realize that this child is a technical bastard." And watching the look of surprise on the faces of the now married couple, he said, "I suppose you know what a technical bastard is, don't you?" "Why, Yes Sir we sho do, that what the town clerk said you were."

Perhaps there's a lesson for us. It does seem that being perfect in the practice of medicine is most desirable but isn't it a shame that some of us become so technical that we become illegitimate? Of course one wonders whether the individual is technical first and then becomes an illegitimate or if the illegitimacy comes first and he is born technical in his illegitimacy. Rather confusing to say the least and perhaps much ado about nothing. My old Grandmother used to say, and now I quote her "There ought to be at least one marriage in every family." We have always adhered to that line of thinking and while we has no real technicians in our family, neither do we have any B. . . . . .s.

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## NEWS ITEMS

Dr. R. C. Smith has been reelected president of the staff of Conway Hospital.

Dr. Edward Proctor was elected vice president, and Dr. Wayne Reeser was chosen secretary-treasurer to succeed Dr. Howard Smith.

The medical staff of Conway Hospital consists of 17 members on the active staff, all resident in Conway, and six members of the courtesy staff, who live in Horry County.

Heading the staff committees for 1954 are Dr. R. C. Smith, chairman of the executive committee; Dr. Clarence Legerton, chairman of the records committee, and Dr. deSaussure Gilland, chairman of the tissue committee.

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Three Ware Shoals physicians are joining together to form the "Ware Shoals Medical Clinic."

Dr. F. C. McLane, well-known Ware Shoals doctor, is moving his offices and equipment to the building on East Main St. now occupied by Dr. H. B. Morgan and Dr. W. J. Holloway. The new "Ware Shoals

Medical Clinic" office hours will be 8 a. m. to 5 p. m., offering medical treatment to the Ware Shoals community.

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Dr. William M. Ragsdale and family have moved to Myrtle Beach from Lake City, and have purchased the house on 64th Avenue North. They plan to make Myrtle Beach their permanent home.

Dr. Ragsdale will share offices with Dr. Carey T. Durant and participate in the general practice of medicine in Myrtle Beach.

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Dr. Vance W. Brabham has resigned as City Health Officer of Orangeburg. Dr. John W. Dantzler has been appointed to succeed Dr. Brabham.

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Plans were announced by the county board for a 30-bed $300,000 hospital to be built in Woodruff. It will be a subsidiary of Spartanburg General Hospital.

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Dr. M. L. Marion of Chester has been elected chief of the medical staff at the Chester County Hospital for the ensuing year. Dr. Marion succeeds Dr. V. P. Patterson of Chester. Dr. A. J. Reinovsky of Great Falls was elected vice president, and Dr. C. W. Brice, Jr. of Chester, secretary and treasurer.

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Ground-breaking ceremonies marked the beginning of construction on the 42-bed Barnwell County Hospital, expected to be completed within a year.

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A local hospital is now being constructed at a cost of $528,000 at Winnsboro.

It is a 30-bed, fireproof, cross-shaped building for white and Negro patients and can be increased to 50 beds.

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Approximately 125 physicians and surgeons of the two Carolinas attended the thirty-third annual meeting and banquet of the Marlboro County Medical Society on January 14 at the Country club. The dinner was served by the Junior Charity League of which Miss Eleanor McColl is president.

The speaker of the evening was Dr. David James of Atlanta, who presented some practical aspects on the management of patients with liver disease. Dr. Charles R. May, president of the host Medical Society, presided.

Distinguished guests attending, in addition to Dr. James, were Dr. Richard Baker of Sumter, president of the South Carolina Medical Association; Dr. Julian Price of Florence, member of the board of trustees of the American Medical Association, and Dr. Kenneth Lynch of Charleston, president of the Medical College of South Carolina.

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The National Foundation for Infantile Paralysis announces the availability of a limited number of post-doctoral fellowships in the field of public health and preventive medicine. The purpose of these National Foundation fellowships is to prepare physicians to fill the many vacancies existing in public health and preventive medicine, with priority to those who are interested in entering the teaching field.

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Dr. Orin Yost, formerly of Orangeburg has opened offices at 211 John Anderson Highway, Ormond Beach, Florida, with practice limited to psychiatry.

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Dr. Walter B. Martin of Norfolk, Va., president-elect of the American Medical Association, was special guest (guest speaker) during the monthly meeting of the Columbia Medical Society held on January 11 at the Columbia Hotel.

# CORRESPONDENCE

Dr. Robert Wilson
Charleston, South Carolina
Dear Dr. Wilson:

I am a licensed physician, a graduate of Loyola University Medical School, at present completing the first year of a residency in internal medicine. I am desirous of obtaining a locum tenens position for the months of July, August, and September, 1954. Any type of position would be satisfactory provided I am able to make the best use of this time in experience, and financially, as I hope to finance the remainder of my residency.

I am 27 years of age, married, with two small children. I would appreciate whatever information you may be able to provide as to possibilities for securing a locum tenens position in your state, and the procedure for obtaining same.

Thank you for your assistance.

Yours truly,
Edwin F. McNichols, M. D.
4057 North Sherman Blvd.
Milwaukee, 16, Wis.

# DEATHS

## H. M. DANIEL

Dr. Homer M. Daniel, 60, well known civic and religious leader of Anderson and for many years one of the most widely known urologists in this area, died at the Veterans Hospital in Columbia January 14 following several months illness.

Dr. Daniel had been in partial retirement since 1946 due to ill health, and suffered a severe stroke about a year ago. He was removed to the veterans hospital last July, and had been a patient there since that time.

A native of Elbert County, Ga., Dr. Daniel was born June 12, 1893, and was graduated from the Emory University School of Medicine in the class of 1916.

Dr. Daniel first began the practice of his profession in the Roberts section of Anderson County, later locating in Anderson following his return from service in World War I.

During his long residence in Anderson he had been prominently identified with the civic and religious life of the community.

# BOOK REVIEWS

**Regional Block, Daniel C. Moore, M. D., Director, Department of Anesthesiology, Mason Clinic and Chief, Anesthesia Division, Virginia Mason Hospital, Seattle, Washington. Charles C. Thomas, Springfield, Illinois, 1953, 345 p. p. and index, 433 illustrations, $11.00.**

**The author divides his book into two parts. The first nine chapters emphasize fundamental considerations involved in all types of regional anesthesia. The necessary instrumentarium, the available anesthetic drugs,**

and the basic methods of manipulating needles and syringes are clearly and concisely outlined. An entire chapter is devoted to the diagnosis and treatment of toxic reactions produced by the use of the regional anesthetic drugs.

The second part describes in minute detail an anatomical approach to the innervation of the various areas of the body. Only one clinically tested approach is cited for each nerve block, yet this justifiable brevity permits, instead, the use of many clear drawings of a semi-diagrammatic form and photographs of actual anatomical dissections of the area. Topical landmarks, in many instances, are clearly illustrated by the use of a skin crayon.

The books is attractively and securely cloth bound by the publisher. The print is large and striking variations in the size and boldness of the headings enhance the readability. The paper is of excellent quality.

The general practitioner, the surgeon who is frequently called upon to perform his own diagnostic and therapeutic nerve blocks, and the anesthesiologist who does an occasional nerve block should find this book desirable. It should prove exceedingly useful as a primer for students desiring a basic foundation in regional nerve blocks before attempting the more complicated, hazardous and less frequently employed nerve blocking procedures.

John Brown

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Review of Physiological Chemistry—Harold A. Harper, Ph. D. 4th Edition, 319 pages—Lithographed type—Paper back—(University Medical Publishers. Los Altos, Calif.) Price $4.00.

This book presents a comprehensive summary of the fundamentals of Physiological Chemistry. Emphasis is placed upon accepted facts and concepts with little of a controversial nature included.

For review, this book presents an excellent outline for the physician who wishes simply to review the subject. For the beginning student it presents an excellent outline of the subject for use with a standard text and with a series of lectures or explanations.

A distinct criticism, however, of this book, from a physicians point of view, is the lack of specific clinical applications of the subject of chemistry to medicine. On this basis it is doubtful that the physician would find this book of much interest.

Wm. McCord

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A Source Book of Medical Terms—by Edmund C. Jaeger D. Sc. — Illustrated — Charles C. Thomas, Springfield—Price $5.50.

From the literary standpoint, much of our medical writing is bad, even after editorial scrutiny. Compare our current journals with those of the British, and see how much better the latter are in readability and in conformity to simple grammatical writing.

Those of us who are given to coining new terms and stretching the meanings of words may well be restrained from too much error by referring to this source book. It gives us the basic origins of words used in medicine, their history and development and their special application. It gives also brief rules used in the synthesis of words.

Nowadays there are fewer and fewer of us who are familiar with the Latin and Greek from which so much of our terminology stems. This book provides a guide and a short cut to the hidden meaning of words unfamiliar to us, and shows by many illustrations the relation of terms used for structures roughly similar—e. g. *ethmos,* a sieve, and the *ethmoid* bone.

With this volume in reach of a ready hand, the average medical writer should be well guarded against the barbarisms which he is rather likely to perpetrate, and should be able to make more telling use of the words which are here dissected for him.

J.I.W.

Respiratory Diseases and Allergy—New Method of Approach by Joseph S. Smul, M. D., Medical Library Company, New York 1953—Price $2.75.

This new approach to respiratory disease adds little, if anything to current knowledge and tends to confuse by the addition of different classification and terminology the already large and vaguely defined field of allergic diseases of the respiratory system.

K. McKee

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Diseases of Women, Robert James Crossen, M. D., F. A. C. S., The C. V. Mosby Co., St. Louis, Mo., 10th Edition, 1953, 935 pages, 990 illustrations, 41 color pages. $18.50.

One's attention is immediately attracted to the bright blue cover with the title "Diseases of Women," in gold against a red background, making the cover more appealing to the eye. This adds rather than detracts from the book, and "eye appeal" is carried further in that the printing is easier to read.

There have been many additions to this book and some worthwhile deletions. The bibliography is now placed at the end of each chapter or special section, which is a definite improvement over the previous editions, where it was placed at the rear of the book. Two special sections have been added and these are: "Endocrine Relations Concerned in the Ovarian Cycle" and "Radiation Therapy." The absence of a discussion of the complications of irradiation therapy for carcinoma of the cervix is sorely missed. The omission of several chapters in the new edition is to conserve space; however, the omission of the chapter "Gynecologic Treatment Measures" will not be missed, for many of the treatments have been discarded.

There is an excellent chapter on "Gynecologic Examination and Diagnosis;" however, I feel that the subject of rectovaginal examination, should have more than a short paragraph devoted to it. Much can be learned on rectovaginal examination that cannot be learned on a vaginal and a rectal examination and its place as a routine part of the gynecologic examination, cannot be over-emphasized.

Notwithstanding the fact that there are other minor points of disagreement, the author and publishers have done an excellent job and are to be congratulated. This book has a place in the library of medical students, general practitioners, obstetricians and gynecologists.

Lawrence L. Hester, Jr., M. D.

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*Pelvic Relaxations and Herniations* By James M. Wilson, M. D., Assistant Professor of Gynecology and Obstetrics; Medical College of South Carolina. Charles C. Thomas, Springfield, Ill.—Price $2.75.

To know and to have an affectionate regard for an author enhances interest in his writings. Since Dr. Wilson is well known and regarded in his native and home state and in North Carolina, where he did his residence work at Duke University, this, his first published work, will elicit widespread interest in this territory.

This little book of some sixty pages was written, says the author in the foreword, for students. Actually, he did not limit it to undergraduate students, and its interest will extend to residents in obstetrics, in gynecology and in general surgery and to practitioners who include the perineum and pelvic structures in their field of interest and practice.

The anatomy and the functional stresses involved in the soft tissues of the female pelvis are notoriously not understood or are misunderstood. Difficulties in obtaining cadavers with uninjured or normally developed pelvic supports, together with the difficulties involved in dissection, have made it necessary for the average student of the subject to obtain his information either piecemeal at the operating table or

from the descriptions and drawings of others. This book will serve as an instructor in the latter category.

Its illustrations, done by Elon Henry Clark of the Department of Medical Art Illustration of Duke University, are well done and easy to understand. The text is well integrated with the illustrations, making the exposition clear.

The book is divided into ten chapters. The first deals with the clinical anatomy of the normal female pelvis. There follow in succession and more or less in the order of the incidence of the conditions treated, chapters on rectocele, cystocele and urethrocele, ureterocele and incontinence, prolapse of the uterus, prolapse of the vaginal vault after hysterectomy, episiotomy, posterior vaginal hernia, levator hernia, obturator hernia, sciatic hernia and herniation into the broad ligament.

The book is not an operation manual. Instead, as the author stresses, "The indication for surgical interference and the principle of repair are considered." As would be expected, coming from the Medical College of South Carolina, the attitude expressed, even stressed, with regard to pelvic surgery, is conservative.

J. Decherd Guess

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*Salt and the Heart, by* E. T. Yorke, M. D. (E. T. Yorke, 1717 N. Wood Ave., Linden, N. J.) Price $3.45

This seems to be an excellent book to recommend to patients who must be put on low sodium diets. It is a well balanced discussion of the subject in terms understandable by the intelligent layman, and some intelligent doctors could read it with benefit. Not a cookbook.

J. A. Boone

# WOMAN'S AUXILIARY

## SOUTH CAROLINA MEDICAL ASSOCIATION

**President: Mrs. David A. Wilson, Greenville, S. C.** **Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.**

### OUR BEST ANSWER TO PROPAGANDA GOOD MD-PATIENT RELATIONS FOSTERED VIA MAGAZINES

With the help of America's writers and advertisers, 1954 may usher in a new era of increased doctor-patient understanding and mutual good will. Here are some examples of how medicine's positive story is being told: Getting the year off to a good start, Parke, Davis & Co. scheduled a public service advertisement on "how to select a family doctor" for the January 11 issue of LIFE. The ad will also appear in Saturday Evening Post, Woman's Home Companion, Parent's Magazine and Today's Health.

In recent months, Better Homes and Gardens (Nov., 1953) published an article entitled "When You Need a Doctor in a Hurry—What Will You Do?" Rotarian (Dec., 1953) ran an article called "Don't Kill Your Doctor," and Look in the Nov. 17, 1953, issue told how "Mississippi Trains Its Own Country Doctors."

A. M. A. has a few copies of these articles. Please let them know if you need them.

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*Other recommended reading*:

*Not As A Stranger* by Morton Thompson. The Literary Guild brochure, "Wings," says of this book: "This is the story about a 'doctor, a man so dedicated to his work that he almost lost the deep human values in his own personal life. This is also a story about the entire medical profession . . . a powerful, behind-the-scenes revelation which takes you straight into the consulting rooms, and opens up the private, hidden lives of patients and doctors alike. This is a stupendous book which has the ring of finality, as though here, at last, in novel form, the subject of medicine has been rendered complete. No doctor would have dared write *Not As A Stranger*—it exposes too much about the profession. Its brilliant author, Morton Thompson, spent many years in researching his book . . . until he knew more about the medical profession than many doctors. This novel is a real reading experience."

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### BILL "S389"

Auxiliary members are urged to become acquainted with the bill in the South Carolina legislature known as Bill "S389." This bill is one which is concerned with the placement of juvenile delinquents, while they await trial, as well as after their offenses have been tried and sentence has been passed.

If the juvenile offender is arrested or sentenced to imprisonment, whether for long or short duration, there is no suitable place for incarcerating him in most of the counties of the state. In a few large cities there have been for some time juvenile courts and accommodations for the punishment for their offenses. But there are numerous examples all over the state where children in gangs or under bad influences have committed crimes and have been lodged in jails with hardened criminals for long periods of time, simply because there was no other place for them.

This bill is one which arouses our interest and command our attention, not as auxiliary members, but as citizens and mothers and individuals who have all health interests at heart. This bill, providing a statewide system of adequate handling of convicted juvenile delinquents, would certainly affect materially the physical, mental, and moral health of the youth of the state.

Legislators who have been reached say that the bill will not be passed unless there is some feeling expressed, some pressure brought to bear by an aroused public.

Public Relations Committee

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### EDISTO AUXILIARY AIDS IN ORGANIZING GREY LADIES CORPS

The Edisto Medical Auxiliary has one new little feather in its cap. It has been instrumental in helping the local Red Cross institute a Corps of Grey Ladies in the Orangeburg Regional Hospital. A number of the doctors' wives took the orientation course along with other interested women of the community and after six weeks are ready to receive their caps and pins. Mrs. J. M. Albergotti, Jr., and Mrs. G. M. Truluck were the two auxiliary members who met with Red Cross officials to "start the ball rolling."

Among the specific jobs undertaken by the Grey Ladies have been the cleaning and straightening of the hospital library and the establishment of an information desk in the lobby, which relieves the telephone operator of interruptions by visitors seeking information. Numerous other services are rendered by these volunteers and as time goes on their presence will be felt even more in the hospital.

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### TODAY'S HEALTH NEEDS YOUR SUPPORT

All Auxiliary members who are proud and happy to do all they can to support positive health education and positive public relations, should support Today's Health.

Don't delay any longer in making an honest effort to increase the sale of subscriptions to Today's Health.

By placing it in physicians and dentist's offices, school libraries, barber shops, beauty parlors, etc., we are helping to bring "accurate views and considered advice of outstanding and dependable medical authorities to the general public in terms that it can understand."

Dr. W. W. Bauer, the able editor of Today's Health, states, "The current operational deficit of the publication would be practically eliminated if every member of the American Medical Association, would become a subscriber."

Your state chairman urges every member of the auxiliary to see that your husband subscribe now to Today's Health and places it in his reception room. It's a "good buy in public relations."

Send all subscriptions to:—Today's Health Circulation, 535 N. Dearborn St., Chicago 10, Illinois.

Orders from Auxiliary members, M. D. and D. D. S. are: 1 year $1.50, 2 years $2.50, 3 years $3.25, 4 years $4.00. The regular rate is $3.00 a year for others.

Mrs. J. W. Bell, Chairman
Today's Health

## PRELIMINARY PROGRAM FOR THE ANNUAL MEETING OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

### Myrtle Beach, S. C.—May 11, 12, 13, 1954

Tuesday, May 11, 1954—Meeting of the House of Delegates.

Wednesday, May 12, 1954—2:00 to 4:00 p. m.

Panel on Non-Tuberculous Diseases of the Chest

Moderator: Dr. D. T. Smith, Durham, N. C.
Medicine: Dr. John Seabury, New Orleans, La.
Pediatrics: Dr. Richard W. Blumberg, Atlanta, Ga.
Surgery: Dr. Rollin A. Daniel, Nashville, Tenn.
Radiology: Dr. Harold Pettit, Charleston, S. C.

Wednesday, May 12, 1954—4:00 p. m.—"The Changing Epidemiological and Clinical Pattern of Pulmonary Tuberculosis"—Dr. D. T. Smith.

Thursday, May 13, 1954

9:15 a. m.—Memorials.
9:30 a. m.—President's Address—Dr. C. R. F. Baker, Sumter, S. C.
10:00 a. m.—"Emergency Treatment of Head Injuries"—Dr. William H. Bridgers, Columbia, S. C.
10:30 a. m.—"The Treatment of Common Skin Diseases"—Dr. Kathleen Riley, Charleston, S. C.
11:00 a. m.—"The Value of Exfoliative Cytology in Diagnosis"—Dr. Rawling Pratt-Thomas, Charleston, S. C.
11:30 a. m.—Time for Visits to Exhibits.
11:45 a. m.—"Common Proctological Problems—Dr. Louis A. Buie, Mayo Clinic, Rochester, Minn.
1:00 p. m.—Luncheon.
2:30 to 4:00 p. m. — Obstetrics — Gynecology — Pediatric Panel. Postmaturity and other neonatal problems
Moderator: Dr. Wm. DeLoache, Greenville, S. C.
Pediatrics: Dr. Amos Christie, Nashville, Tenn.
Obs.-Gynecology: Dr. Norman Thornton, Charlottesville, Va.
Also
2:30 to 4:00 p. m.—Medical-Surgical Panel on Peptic Ulcer
Moderator: Dr. Henry Mayo, Charleston, S. C.
Internist: Dr. Franz J. Ingelfinger, Boston, Mass.
Surgical: Dr. Cranston W. Holman, New York, N. Y.
Radiologist: Dr. George J. Baylin, Durham, N. C.
4:00 p. m.—Visits to exhibits.
4:15 p. m.—"The Treatment of Liver Disease,"—Dr. Franz J. Ingelfinger, Boston, Mass.
5:00 p. m.—Adjournment.
7:00 p. m.—Cocktails. (Courtesy of Van Pelt and Brown).
8:00 p. m.—Banquet. Address by The Hon. James F. Byrnes

# THE TEN POINT PROGRAM

M. L. MEADORS, Executive Secretary and Counsel

## THE FUTURE OF PRIVATE PRACTICE

Addressing the Medical Society of the County of New York in January, as reported in New York Medicine, Dr. Chester S. Keefer, Special Assistant to the Secretary for Health and Medical Affairs of the U. S. Department of Health, Education and Welfare, made some interesting forecasts with respect to the future of the private practice of medicine in this country. He acknowledged that any predictions concerning this subject are "extremely hazardous," but in view of the discussion which has taken place within the past fifty years, he points out that it is well to review the subject periodically. He quoted a pertinent paragraph from an essay on the same subjects by the late Dr. Frank Billings in 1921, which serves to emphasize the fact that the current situation had its beginnings at least more than thirty years ago, and that they are, to some extent at least, inherent in the nature of the economic development of the United States:

"In the evolution of modern life, society has been and still is characterized by financial greed and by extravagant expenditures for luxuries and pleasures which appeal to the physical rather than to the spiritual man. The cities afford opportunity for display, social pleasures, and for possible success in a professional and financial way. This tempts migration of the professional and the business man, including the young men of the farm, from the country to the city. This migration has increased within the last few years in spite of the more livable conditions of village and rural life, through the advantages of rural free delivery, the inter-urban trolley and motor cars. At the present time more than half the population of the United States is urban. Thus there is an excess of physicians beyond the need of the city public, and a dearth of medical men to supply the need of the rural population. This breeds discontent and disappointment in the medical profession in the city, and the rural public suffers from the need of a sufficient number of doctors. The country physician lacks modern facilities for diagnosis and for the needed hospital treatment of his patients."

Dr. Keefer believes that "The trends and shifts of emphasis in medical practice indicate that the physician and the profession will determine the nature of medical practice in the future as in the past. However, the medical profession will determine their future and their destiny only if they continue to consider themselves a part of the general public. The profession must be devoted to the welfare of the public and continue its practice and pursue the art of medicine as a public service. The tradition of the medical profession is a duty to the patient, to the profession, and to the public."

Stressing further the obligation and the opportunity of the medical profession in determining its future, the speaker made these observations, with which, of course, we are all quite familiar and in agreement, but which some are perhaps prone at times to overlook:

"All physicians have rights as citizens and as a profession. But, in addition to rights, the medical profession has certain privileges and perogatives which are allowed by the people and enjoyed under the law. These privileges are permitted by the public by reason of confidence in the integrity of the profession and in the belief of its general beneficence and by right of specialized knowledge. The medical profession exists only as the people allow it to maintain its perogatives. We should be acutely aware of these privileges and appreciate what the profession enjoys. Those who are conscientious will not take advantage of these privileges. Those who are thoughtless—and certainly those who are not entirely honest—will do so."

He called attention to an expression by Dr. Atchley of Columbia University in a recent issue of *The Saturday Review*, to the effect that "the medical profession has only recently progressed to the synthesis of its own separate and often antagonistic aims through fusion of the old art of healing with the relatively new science of medicine;" and Dr. Keefer believes that each physician, individually and through his medical society, is contributing toward that "synthesis" in his work toward improving public relations, physician-hospital relationships, voluntary health insurance, and the level of public understanding of health problems.

Developments which have contributed largely to the change in the private practice of medicine were interestingly traced. The effect of some of these developments is by no means complete, but will continue to be felt in greater degree in the years to come. Apparently, it is Dr. Keefer's idea, also, that the continued interplay of certain of these developments will lead eventually back to some semblance of the relationships between patients and patients' families and the physician which were so highly prized a few decades ago, and that the relationships will be vastly improved and made more highly satisfactory to patient and physician alike. These elements were discussed:

*"The Family Doctor.* In 1923, about 1 in 10 of the 146,000 physicians in the United States limited his practice to some specialty. In 1949, the proportion of full specialists had increased to 3 in 10. The decline in the resulting proportion of physicians who gave all or part of their time to general or family practice is perhaps one of the most deplorable developments in the period and may well be at the root of many of the problems of medical care today . . . . Nostalgically the patients of today look to all physicians for the same type of sympathetic interest in their personal problems; yet at the same time they want the best in modern scientific medicine. The family doctor of 30

years ago would have been puzzled at the need to write books with such titles as 'Patients are People,' 'Patients Have Families.' Increasingly the doctor of today and tomorrow, as healer and scientist combined, will find satisfaction and reward in family practice, for medicine is being guided back to primary preoccupation with a person as a human being."

Dr. Keefer sees the doctor of the future "as the most important single unit in medical care." He thinks that, "Like the family doctor of the past, the family physician of the future should serve as health advisor and health educator and as a leader in developing the health resources of the community." By reason of the vastly greater resources at his command, however, the family doctor of the future will differ greatly from that of the past.

"*Specialism.* The specialist is and will of course remain an essential, necessary and important person in medical care. As medical knowledge expands, new specialties will emerge, each requiring years of study to assimilate and augment techniques of diagnosis and treatment. In the future, however, specialists can be used more wisely if their services are properly correlated with those of the family doctor.

"Our problems of the past have derived mainly from the isolation of the various specialists from each other and from the lack of 'generalists' to interpret and integrate the several fields. In pediatrics, however, and in the emerging specialty of geriatrics, the specialists are also generalists for a whole age group. We need to develop equally rewarding concentration on the total person in his most productive years of life. The family doctor will help to fill this gap."

Group practice for home and office care is a more recent but considered an equally significant development. It is said to achieve "economy by avoiding duplication of expensive equipment and that it ideally provides the link between the personal physician and a wide range of specialists." The upward trend in this type of practice is indicated in the rise from a total of 239 groups in 1932 to an estimated 500 in 1950, and this, said the speaker, is expected to continue.

*Hospital Care.* The far wider use of institutional care is of course generally recognized and understood. According to Dr. Keefer, admissions to registered hospitals in 1934 represented 61 persons per 1000 population, and by 1952 the admission rate reached 121.4 per 1000 population. The tendency toward development of separate and specialized types of institutions for the care of chronic or other long-term cases was pointed out, along with the recognition of the need for nursing and convalescent facilities and home-care programs. The importance of this particular phase of hospitalization was given unusual emphasis lately through the recommendation by President Eisenhower in his Health Message to Congress for amendments to the Hill-Burton Law in order to permit the use of Federal funds for the building of such hospitals.

*Medical Care Insurance.* The remarkable growth and expansion of medical care insurance was referred to as "an almost revolutionary factor in medical practice." In Dr. Keefer's opinion, and despite the number of people covered by some form of such insurance, the present provisions have several serious gaps:

"1. The effect of health insurance on the utilization of physicians' services for periodic health examinations and home and office care should be extended. A 1952 Medical Economics Survey found that private practitioners see nearly three-fourths of the average daily number of patients in their offices. Home visits and hospital visits represented about one-tenth and one-fifth, respectively, of their daily patient load . . . .

"2. Ways must be found to extend health insurance protection to individuals as well as to groups and to cover aged, retired people and those with existing health defects. To maintain solvency and to keep premiums within the range of most family budgets, insurance agencies find it necessary to avoid or minimize the danger of covering a large proportion of unhealthy people . . . .

"3. Ways must be found to expand and intensify rehabilitative efforts so that persons suffering from disabling chronic illness and defects may be restored to usefulness."

The role of research and education was recognized as a most important one. In the words of the speaker, "As teachers, practitioners, research workers, and community leaders we *build* the future of medicine from our knowledge and experience of the past." And, he pointed out, our resources in this particular task are many, and both public and private support for medical education can be depended upon.

*The Federal Role.* In summarizing the role of the Federal Government in connection with these expected developments in the private practice of medicine, Dr. Keefer outlined fairly closely the suggestions and recommendations which have been made by the President in his State of the Union message and his Health Message in January. He believes that "our new approach" to the solution of the problems in filling the gaps in voluntary insurance through co-operative effort "assures sound solutions without the danger of Government control of medicine," and he thinks that the problems that lie ahead for the private practice of medicine must be studied and determined by professional and lay people alike in a sense of fairness and with the desire to afford justice for all concerned.

"In considering the measures which must be instituted to improve the health of the people and the future practice of medicine, we as a profession must keep in mind the general welfare of the public."

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## HOMEOPATHIC BOARD PROPOSED

There is good reason to believe that the bill (S.504) introduced into the Senate on February 3, 1954, for the purpose of authorizing the creation of a Board of Homeopathic Medical Examiners is not all it may appear to be on its face, or on the other hand, that it may be considerably more. A little less than a year ago, the Executive Offices of the South Carolina Medical Association received information in writing from a most reliable source to the effect that such a bill

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| AUTHORS | No. of Patients | Chronic, Resistant to Other Therapy | TYPES OF ULCERS | | | | RELIEF OF SYMPTOMS (Chiefly Pain) | | | | Surgery or Complications[1] | Side Effects Requiring Discontinuance of Drug[2] | EVIDENCE OF HEALING | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Duodenal | Jejunal | Stomal | Gastric | Good | Fair | Poor | No Report | | | Complete | Moderate | None | No Report |
| Grimson, Lyons, Reeves | 100 | 100 | 93 | 7 | | | 80 | 11 | 4 | | 5 | | 47 | | 19 | 29 |
| Friedman | 15 | 15 | 14 | | | 1 | 5 | | 4 | 6[3] | | | 2 | | | 13 |
| Bechgaard, Nielsen, Bang, Gruelund, Tobiassen | 26 | 26 | 21 | | | 5 | 16 | 4 | 6 | | | | 8 | 6 | 12 | |
| McHardy, Browne, Edwards, Marek, Ward | 162 | | 162 | | | | 136 | 12 | 11 | | 3 | 1 | 14 | 9 | 7 | 129 |
| Segal, Friedman, Watson | 34 | 34 | 34[4] | | | | 14 | 13 | | | 7 | 2 | 5 | | 8 | 14 |
| Brown, Collins | 117 | 99 | 117 | | | | 97 | 7 | 8 | | 5 | 8 | 55 | 9 | 8 | 40 |
| Asher | 77 | | 65 | | 7 | 5 | 52 | 9 | 16 | | | 16 | | 9 | 21 | 47 |
| Rodriguez de la Vega, Reyes Diaz | 5 | 4 | 5 | | | | 4 | | 1 | | | | | 3 | 2 | |
| Winkelstein | 116 | 116 | 102 | 8 | | 6 | 102 | | 14 | | | | 53 | | 18 | 45 |
| Hall, Hornisher, Weeks | 18 | 18 | 18 | | | | 11 | | 1 | 6[5] | | | 18 | | | |
| Maier, Meili | 38 | 38 | 24 | | | 14[6] | 27 | 7 | 4[7] | | | | 10 | 2 | 5 | 21 |
| Meyer, Jarman | 25 | 18 | 25 | | | | 21 | | 4 | | | | | | | 25 |
| Poth, Fromm | 37 | 37 | 37 | | | | 33 | 3 | 1 | | | | 33 | 3 | 1 | |
| Plummer, Burke, Williams | 41 | 41 | 41 | | | | 36 | | 5 | | | | 38 | | 3 | |
| McDonough, O'Neil | 104 | 100 | 104 | | | | 63 | 10 | 31 | | | 11 | 4 | | 11 | 89 |
| Broders | 60 | 60 | 58 | | 1 | 1 | 35 | 19 | 6 | | | | 10 | 1 | 49[8] | |
| Legerton, Texter, Ruffin | 11 | | 11 | | | | 11 | | | | | | | | | 11 |
| Holoubek, Holoubek, Langford | 76 | 69 | 76 | | | | 35 | 27 | 10 | | 4 | 10 | 26 | | 10 | 36 |
| Ogborn | 42 | | 39 | 2 | | 1 | 42[9] | | | | | | | | | 42 |
| Shaiken | 48 | 48 | 48 | | | | 33 | 10 | 3 | | 2 | | 33 | 10 | 3 | |
| Johnston | 145 | 145 | 145 | | | | 143 | | 2 | | | 2 | 143 | | 2 | |
| Rossett, Knox, Stephenson | 146 | | 141 | | | 5 | 146 | | | | | 4[10] | 53 | | | 93 |
| TOTALS | *1443* | *968* | *1380* | *17* | *8* | *38* | *1142* | *132* | *131* | *12* | *26* | *54* | *552* | *53* | *179* | *634* |
| PERCENTAGES | | *67.8* | *95.6* | *1.2* | *0.6* | *2.6* | *81.3* | *9.4* | *9.3* | | *3.7* | | *70.5* | *6.6* | *22.9* | |

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

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would be introduced in South Carolina. Included with the letter were copies of correspondence indicating very strongly, or leading to the almost inescapable conclusion that the general purpose of the introduction of the bill and the legalizing of the issuance of license to practitioners there under would be to make possible the securing of homeopathic licenses with little regard to the training and qualifications of the applicants. A portion of the information which was brought to our attention at that time was quoted from a Naturopathic publication, and dealt with the activities of "a certain past president of a naturopathic association." In all fairness, it must be stated, that the attitude of the publication and others involved at that time was strongly condemnatory of the proposed move. On the face of the information presently available, there is no apparent connection or relationship whatever between the sponsors of the proposed measure and recognized practitioners of homeopathic medicine or any of its regular organizations. The bill was introduced by Senator Mozingo of Darlington County and nothing contained in this article is intended to cast any reflection or criticism upon the Senator for his espousal of the cause. As a matter of fact, we have no idea that Senator Mozingo is aware of the implications of the proposed measure which he introduced.

The bill, which was referred to briefly in the February Newsletter, would if adopted, create a Board of Homeopathic Medical Examiners consisting of five, four of whom would be "physicians of homeopathic schooling and members in good standing of the South Carolina Homeopathic Council." The fifth member would be a medical doctor appointed by the Governor upon the recommendation of the State Board of Medical Examiners. All members would serve for a term of four years. The Board would be directed to hold two examinations a year on the following subjects: Anatomy, Physiology, Hygiene and Sanitation, Materia Medica and Therapeutics, Chemistry, Pediatrics, Urinalysis, Bacteriology, Pathology, Surgery, Principles of Practice, Obstetrics and Gynecology, "and any other subjects which the Board may deem necessary or advisable." The examinations would be "either written, oral, or practical laboratory or bedside examination or a combination of any of them."

Applicants would be required (1) to be not less than 21 years of age, (2) to exhibit a diploma conferring upon him the degree of Doctor of Medicine "from a legally chartered and reputable medical school or college recognized by the Board" and (3) also to produce certified credentials of preliminary education, and certificates as to moral character and sobriety by at least "two physicians acceptable to the Board," similar to those usually required in such cases. A deposit of $25.00 as a license fee would also be requisite to taking the examination. Graduates of foreign medical schools would be admitted after meeting "such qualifications as the Board may reasonably require."

The simple reference to the educational qualifications required of applicants as quoted above from the bill, should be sufficient to indicate the nature of the business proposed. The only evidence of professional education required is the presentation of a diploma conferring the degree of Doctor of Medicine from a legally chartered and reputable medical school or college recognized by the Board. The courses or the length of terms or hours of study are not even pretended to be indicated. Obviously, whether or not such school or college were "reputable" would be a matter for determination by the Board.

The South Carolina Homeopathic Council referred to in Section 1 of the Bill is not further defined. On December 7, 1951, however, a charter of the State of South Carolina was issued by the Secretary of State to the South Carolina Homeopathic Society. Its officers were Edward R. Huffman, president and treasurer, and William Schindeldecker, vice president and secretary.

Full information concerning the background and the obvious implications of the proposed bill is in the hands of the Legislative Committee of the South Carolina Medical Association. The Senate Committee on Medical Affairs, Hon. W. P. Baskin of Bishopville, Chairman, to which the bill was referred, has been requested to hold a Hearing if, and prior to the time, any action is taken. The matter will be carefully watched but in view of the probable brief Session, there seems little likelihood that the proposed measure will make progress this year.

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## THE DOCTOR AND THE PRESS

The highly capable "Observer" of the *Medical Annals of the District of Columbia* so frequently expresses quotable views that we cannot resist the temptation to quote him fairly often. In the February issue of the *Annals*, in his department, "In and Out of Focus," there is an excellent treatment of the troublesome subject of doctors and the press. The following are the views expressed by Mr. Wiprud, Executive Secretary of the District's Medical Society, which we feel are highly worthy of passing on for the benefit of the members of the South Carolina Medical Association:

1. There is nothing as perishable as a newspaper 'story.' Yesterday's news is all but forgotten except by a small minority who because of some personal interest recall what "stood in the paper." There are too many world-shaking events for an ordinary incident to hold more than fleeting attention.

2. Nothing can be gained by keeping alive controversial issues unless they are of such momentous nature as to warrant it. Issuing statements or writing communications to the editor usually serve only to stimulate those who disagree to write more statements and communications.

3. There is no such thing as having 'our side' presented to the exclusion of those who do not agree with us. Most newspapers endeavor to present both sides of an issue, but complete objectivity is rare, human nature being what it is. Reporters, as your Observer has written previously, are influenced in what they write by their background, experience and

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troubles.

4. It should not be necessary to state that doctors or their medical organizations are not infallible. They make mistakes like everyone else. Some of them are news and a few make the headlines. When this occurs, physicians should submit to the inevitable with good grace.

5. Without wishing to minimize the influence of the press, causes are seldom won or lost because of individual or sporadic news articles. Some years ago, upon the suggestion of the Medical Society, a local newspaper began an investigation of a medical institution with the result that shortly thereafter very critical and highly provocative articles appeared, directing attention to the deplorable conditions which existed in the institution. Six months later your Observer learned that nothing had been done to correct the situation, so he called it to the attention of the newspaper, which again published a series of excoriating articles. Under these circumstances one would think that public indignation would be such that something would be done; but the situation remained as it was for several months thereafter. Even today conditions at this institution are not what they should be.

Long and persistent effort is required to remedy as bad a situation as this was, including the wholehearted and continuous support of one or more newspapers.

In the light of these observations, what should individual physicians and medical organizations do to obtain generally favorable treatment by the press? Here are a few suggestions:

1. They should see to it that the press has knowledge of all constructive efforts made by the medical profession to protect and improve the public health.

2. Where there are injustices, they should see to it that their 'story' is told at the proper time. Negativism, however, can only lead to public disapproval and an unfriendly press.

3. Wherever and whenever conditions warrant, officials of medical organizations should discuss frankly with press representatives the problems facing the profession. Under proper circumstances, this can also be done by individual physicians. In either instance, it may be desirable to do so for the purpose of providing background information only and not with a view of being quoted or credited with supplying the information.

While it is what medical organizations do and not what they say which counts most, it is important that they say what they have to say at the proper time. It is as simple as that!

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